103

S. HRG. 103–973

FIGHTING FAMILY VIOLENCE: RESPONSES OF THE HEALTH CARE SYSTEM

Y 4. AG 4: S. HRG. 103-973

Fighting Family Violence: Responses...

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

BANGOR, MAINE

JUNE 20, 1994

Serial No. 103–22

APR 11 1995

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

83–927 WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046776-4

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FIGHTING FAMILY VIOLENCE: RESPONSE OF THE HEALTH CARE SYSTEM

MONDAY, JUNE 20, 1994

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Bangor, ME.

The Committee met, pursuant to notice, at 9 a.m. at the Bangor Civic Center, Bangor, Maine, Hon. William S. Cohen (acting chairman of the Committee) presiding.

Present: Senator Cohen.

OPENING STATEMENT OF SENATOR WILLIAM S. COHEN, ACTING CHAIRMAN

Senator COHEN. Ladies and gentlemen, we are going to commence the hearing this morning. Let me begin by welcoming you to this special hearing of the Special Committee on Aging dealing with fighting family violence.

Violence is an epidemic that has reached staggering proportions in this country. The 1980's arguably were the most violent decade of the century, if not in U.S. history, and the 1990's threaten to be even worse.

On an average day, physical violence kills 65 people and injures 6,000 more. This is more than twice the casualty rate that our Nation sustained at the height of the Vietnam War. In fact, in the last 5 years, we have lost more Americans to violence than we lost in Korea and Vietnam combined.

None of us are immune to this epidemic. Violence knows no geographic, age, ethnic, or economic boundaries. It's not confined to low income or inner-city housing projects.

It reaches the homes of the wealthy and the famous, as we have been reminded over and over this past week due to the widespread media attention to the murder of O.J. Simpson's ex-wife and allegations of domestic violence in that case.

Any problem causing so much injury and death is clearly a major health care problem. Violent behavior adds more than $13 billion to our Nation's health care budget each year.

Former Surgeon General C. Everett Koop has called violence one of the major public health threats facing America today, as much a public health issue as communicable disease control was during the last two centuries.

And leaders of the health care community have begun to call violence a public health threat on a par with tuberculosis, cancer, and AIDS.

We have to focus on what we can do to prevent violence and intervene at the earliest stages, first and foremost to rescue its victims, but also to save billions in health care costs.

Failing to do all that we can to prevent further violence is like the parable about a man who was pulling people out of the river. Someone came up to him and said, "Listen, a mile upstream there's somebody throwing these people in, and you'd save yourself a lot of time and trouble if you'd just go up and stop him."

The man responded, "But I haven't got time. I've got to save all of these people who are drowning."

The criminal justice system responds to violence reactively. It looks for blame and tries to punish after the event has occurred. It is time to use our public health and medical communities to go upstream in our attempts to combat violence.

The public health approach, which has been successful in dealing with problems like contagious disease, emphasizes intervention and prevention. It looks for risk factors and tries to reduce them.

Clearly there is no pill or vaccine that is powerful enough to put an end to violence, and the health care community will never be a substitute for our criminal justice or social service systems. However, it can be an important complement to these systems.

Health professionals, for example, can be effective in areas like family violence where the response of the criminal justice system has been lacking. The health professions' role in addressing family violence is the focus of this hearing today.

Sadly, in the United States, family violence is about as common as giving birth. There are about 4 million instances of each annually. Family violence, which includes child, spouse, and elder abuse, is a serious and a widespread problem that doesn't discriminate. As I indicated before, it affects all economic, educational, social, geographic, racial, and ethnic groups.

One of the common myths about domestic violence is that it is predominantly an urban problem. However, we're going to hear some compelling testimony from our witnesses this morning which will illustrate that living in a rural State like Maine does not decrease the individual's risk of family violence.

In fact, the isolation of rural life makes the violence less visible and allows the abusers to imprison their victims more easily by limiting their contact with the outside world. With no public transportation and few neighbors nearby, battered women, children, or older persons simply cannot escape their terror.

In Maine, a domestic assault occurs at least once every hour and 58 minutes. About 40 percent of all the assaults in Maine occurred between family members, and almost 75 percent involved females assaulted by males.

There were some 6,500 cases of child abuse or neglect referred to the Maine Department of Human Services last year. These are truly staggering numbers. This is not, to quote a popular State slogan, "The way life ought to be."

As the ranking member of the Senate Special Committee on Aging, I am particularly concerned about the older persons who have been mistreated by their spouses, their adult children, or their caretakers.

Most experts agree that elder abuse is one of the most underrecognized and therefore underreported social problems in this country. Because the victims of elder abuse tend to be dependent, frail, ill, or even mentally impaired, they are among the most vulnerable victims of domestic violence.

Physicians, nurses, and other health care providers have a critical role to play in treating and preventing family violence. After all, they are often the first ones to see the consequences of that violence, the broken bones, the displaced shoulders, the emotional trauma, in hospital emergency rooms, physicians' offices, and in community health centers.

They are often in a unique position to identify, diagnose, treat, and refer victims of family violence to a battered women's shelter, an emergency hotline, or some other source of help.

Unfortunately, however, there has been a general reluctance on the part of physicians and other health providers to get involved. Some doctors have likened addressing domestic violence in the clinical setting to opening Pandora's box. As a whole, the health care community's response needs to be far stronger than it is today.

When asked to rate the effectiveness of helping professionals, battered women gave lower ratings to medical professionals than to lawyers, clergy, police, social service agencies, battered women's shelters or women's groups.

The reluctance on the part of health care providers to ask so-called prying questions about their patients' personal lives and relationships can result in their missing important clues that could lead to an accurate diagnosis and the prevention of further injury and, in some cases, even death.

Therefore, I hope that this hearing will help us to explore the proper role of health care providers in treating and preventing family violence and also to develop some strategies for breaking down the barriers to their involvement.

Of course, we have to remind ourselves, all of us, that health care providers alone can't shoulder the responsibility for curbing family violence. Successful prevention efforts require the commitment, the cooperation, and coordination of many resources throughout the community.

Unfortunately, at present our efforts to combat family violence are fragmented and limited. Therefore, this morning we are also going to be hearing from representatives of the criminal justice and social service systems who will tell us about their efforts to help stem the tide of family violence.

They will help us identify ways that the health care, criminal justice, and social service agencies and systems can work together to combat family violence to make better use of our resources and ensure that victims in our communities get the help and protection they need.

While this morning's hearing is focused on the very serious problem of domestic violence, it should also lead us to question the way we, as a society, respond to violence in general.

Our society unfortunately has embraced violence as part of our culture. We glorify violence in movies, on television, in rap music, and in the video games played by our children.

The same societal attitudes that tolerate violence in our society also tolerate violence in our homes. We are tragically teaching our children that violent behavior is acceptable and they are, regrettably, learning these lessons very well.

This constant exposure to violent behavior has numbed us, and particularly our children and young people, to the actual pain that violence inflicts. We have been conditioned to accept violence as a natural and inevitable part of our lives.

The recent well-publicized incident in which a group of junior high school students were laughing at the depiction of a summary execution of a young Jewish woman in the move "Schindler's List," I think, is an example of just how desensitized we are becoming.

We have already made some progress in the campaign against family violence. To help combat the escalation of violent crime against women, for example, the Senate recently passed the Violence Against Women Act which I introduced to address the broad scope of violent crimes against women, both in the streets and in their homes. This legislation is now part of the Omnibus Crime Bill which is pending in conference and hopefully will be voted on within the next several weeks.

The Crime Bill also includes a proposal of mine to provide better protection for the elderly against caregivers who abuse them physically, emotionally, or even financially. This proposal will allow agencies and other groups providing home care and other services to the elderly or disabled to have access to FBI information so they can check to see if the caregivers have criminal records.

This is quite similar to what Congress passed recently as a safeguard for child care facilities. And I think it's only appropriate, if we are going to extend this kind of protection to our children, we also extend it to our elderly and to our disabled.

These are some steps in the right direction, but we have to do a great deal more to stem this tide of violence that is destroying our families and drowning our future generations.

Before turning to the first panel, I would like to take a moment to recognize U.S. Attorney Jay McCloskey who had planned to be here today.

For many years, Jay has served as Assistant U.S. Attorney and now as the U.S. Attorney. He has been actively involved in combating violent crime, and I appreciate him taking the time to be with us to listen to the presentation this morning.

In addition, I want to give special recognition to Fleet Bank Youth Leaders from Houlton Junior High School who are also here with us this morning. These students recently received one of three awards given throughout the State for a project that they initiated to increase awareness about where abused women and children in the community could obtain help, and also to increase awareness about violence in teen dating.

They used the fundraising proceeds from a dance and a bottle drive to design, print, and distribute 250 posters with the hotline number for the Battered Women's Project and some 2,000 brochures on violence in teen dating.

The brochures were distributed to surrounding school districts and the posters were placed in the hospital, doctors' offices, grocery stores, and welfare offices throughout Houlton and the entire sur-

rounding area. I understand the community response was overwhelmingly positive.

This is but one example of how we can take positive steps to combat violence in our communities, and I hope that you will join me in congratulating them on their tremendous success.

[Applause.]

I want to welcome our first panel of witnesses, who will go by the names of Grace, Roberta, and Sharon. All three of these women have been victims of family violence. They have graciously agreed to share their painful and indeed often harrowing experiences and stories with us.

And it's because I believe that their testimony will help ensure that measures are taken to protect other women who are victims of violence that I have asked each of them to be here today.

So if Roberta, Sharon, and Grace would step forward, we will be pleased to hear from you.

Roberta, we are going to make you the lead-off witness.

STATEMENT OF "ROBERTA," VICTIM, OF AROOSTOOK COUNTY, ME

ROBERTA. Hello. My name is Roberta, and I would like to share my experience with you in hopes that it will help bring a greater understanding of domestic violence.

My children and I are the survivors of 6 terrifying years of suffering—physical, emotional, mental, and sexual abuse. We lived in a constant state of fear and confusion.

It has been said that women should stay at home where it is safe, but as you know there are many women like myself, hundreds of thousands of women and children who are not safe even in their own homes.

I had a very simple and beautiful dream, to have an all-American happy family, to provide my children with a good home filled with love, peace, and joy, memories for us to cherish. I just could not figure out what I was doing wrong. My intentions were good, but somehow the results ended up horrifying.

Ed repeatedly told me that I was inadequate, that I was the cause of all our problems. I believed him. I was so focused on keeping this man happy that I lost my own identity.

I accepted the responsibility for his actions. I denied and minimized his violence. I blamed our problems on alcohol. I blamed financial insecurity. I did not hold him accountable for any of his actions.

I had to keep my family whole after all; my sacrifices and energies were invested in my beautiful dream. I refused to believe that Ed was a batterer and the children and I his victims.

One night when we lived in New Hampshire, after one of Ed's rages, he locked me out of our house. I was in my nightgown, outdoors, watching as he left with the children.

I walked 3 miles in the pitch dark, barefooted, hiding from passing vehicles because I was embarrassed. What I must look like, all beaten up, hair all a mess, half-naked, wandering down the highway in the middle of the night. I was beside myself, worried for the children's safety.

I made it to the police station. They called the local battered women's project. I refused their help initially, angry that they assumed I was one of those women. But with the help from local authorities, I did obtain a temporary restraining order and custody of the children. I saw this as a way that Ed would take me seriously. It would make him stop the abuse.

He was allowed visitation with the children on Saturdays, and I arranged for the transfer to take place at the police station. Life was not easy for me. I was a single parent of two small children. I had all the responsibilities of providing for their needs. I had to work. Transportation and babysitters were a big problem. I worked 50 hours a week waitressing and cooking, and that left me very tired, discouraged, lonely, and scared.

The children wanted daddy back. They seemed happy on Saturdays. Daddy would bring them goodies and spend the whole day having fun. Ed looked better than I had seen him in a while. He said that he'd changed. He wanted to come home. He promised the abuse would end. He tried to prove it by joining a substance abuse program and got a good job. He even paid me child support. And he complied with the terms of the protection order.

After a short time, probably a couple of months, I relented and informed the court of our reconciliation, requesting to dismiss the protection order.

All went well for a while. I started to believe that we could live happily together. Then Ed got money from a legal settlement, quit his job, and celebrated for 6 weeks. I didn't see much of him. I was hurt. How could he be so selfish?

Then one day he pulled into our driveway with a U–Haul and said he was buying a house in northern Maine and was taking the children with him. I was hesitant at first but was excited that we would finally own our own home. I was also hoping for a fresh start away from old habits.

Ed bought a house in Sherman Mills, Maine, 5 hours' drive from anyone or anything that was familiar. It was a very rural area and that concerned me. I felt so isolated but determined and hopeful.

We began immediately to make our house a home with painting and landscaping. I took a waitress job to make mortgage payments and Ed unsuccessfully looked for work for 6 months. He refused to work for minimum wage.

He began to drink heavily. He accused me of being unsociable when I complained about his drinking and wouldn't join him. He told me it was his house and if I didn't like it, I could leave, without the children, of course.

One night I returned from work, and no one was home. I found Ed down the road in a tar paper shack, drunk, but no children. He had left them with complete strangers. I got the address and tried to get the children quickly, but Ed got there first, telling the strangers that he didn't know why I was so upset. He said that I was crazy.

He insisted that I not take both the children, so I took our daughter and he took our son. He was very intoxicated. As I followed him, I watched terrified that he would have an accident and hurt our son. Miraculously, we all made it home.

He was abusive the following morning and again locked me out of our house. I told my boss about what was happening in my life, and she gave me the number to the local battered women's project.

I called the State Police to get the children from Ed, who I know was driving with them while intoxicated. I called the battered women's project, and they advised me to come in to shelter. But I was still in denial. There was no way I was taking my children from their home into some shelter where they probably lined up the cots.

I was advised to get a protection order so I could live with my children in my home without abuse. But I had done that before and I know I would be alone in the middle of the northern Maine woods, no babysitter, no work, no money, no family. It was easier for me to forgive Ed.

I believed if I gave him another chance and he stopped drinking and he would just grow up, then things would get better in time. So Ed came back again. And I was determined to make things work, to help Ed, to save Ed.

I got a 40 hour per week job and so did Ed. We worked opposite shifts so we could save money on sitters. Ed also to my surprise got a new plan. He presented me with a paper he called a prenuptial agreement that gave him custody of the children, the house, and everything in it. I reluctantly signed the paper because he said that was the only way I could maintain contact with the children. Once I signed it, he locked me out again.

I searched for a place to live while continuing to give Ed half of my paycheck. He allowed me to visit daily and to cook and clean for them. I slept anyplace I could find a bed, living with various people, and I started to drink but only after work. I know I was in trouble. I should not have been drinking at all.

I begged Ed to let me move back, but he laughed at me and refused. I finally figured it all out. I know that Ed would always mistreat me and that there was no love left in the relationship. There probably never was.

I picked myself up and worked hard to get through this ordeal. Ed used the children as a weapon to control me, but I told him I would get a lawyer and fight for my parental rights. I stayed away from Ed except to see the children.

I began dating a man I had met, and Ed literally lost all control. He decided that I was his, would always be his, and he would never let me be with anyone else. He threatened me and my friend.

Then Ed lured me in and set a new trap. On one visit with the children, Ed assaulted me and threatened me with a knife as the children watched terrified. As soon as I could, I filed an assault complaint with the State police.

Ed went to the local district court and alleged that I had tried to stab him, that I was mentally disturbed and that he was afraid for his and the children's lives. He got an emergency protection from abuse order on behalf of the children against me, giving him sole custody until a full hearing.

Needless to say, I was very upset. The night before the hearing I agreed to talk to Ed in hopes of getting him to tell the truth. He kept me up all night, making me promise to dismiss the assault charge and then he would dismiss the protection order. I agreed.

The following morning I arrived at the district court 1 hour late and discovered that the judge had granted Ed a full order for protection for 1 year, allowing me only supervised visitation, 4 hours each Saturday, and Ed was to supervise the visits.

I was shocked. I could not believe this was happening. Ed had abused me and then the legal system and won. I felt total defeat. I was being victimized again, this time by the system that I thought would protect me.

Somehow I had lost everything, just like Ed had threatened. He got the children, the house, my personal belongings, and everything that meant anything to me. I was heartbroken and scared. To add insult to injury, the court also ordered that I pay Ed child support, when I had been supporting him all along. I guess that I was naive thinking that justice would prevail.

When Ed was granted the full order, I began to believe all his degrading statements. I must have been a lousy person. I must not have been a good mother. I must not have cared for the children as good as he did, and I must not have deserved a home.

I began to drink a little more. It helped me get by my intense feelings of sadness and pain. I tried to numb myself, to escape reality. I did not wallow in this self pity long though. I picked myself up and found the determination to fight the injustice. I made plans to get my children back.

I paid the court ordered child support. I visited with the children regularly with Ed's humiliating supervision. He made it impossible for the visits to be pleasant, but I went anyway.

I quit drinking. I started to see therapists, one for substance abuse and one for other issues. I worked hard at rehabilitation and wellness. I know that I must be strong if I was going to win this battle.

Ed kept on abusing me and the system. He reported me to the State Police three times for violating the protection order. The State Police did not arrest me. They knew that I was not the abuser. But under the law they had to charge me with the reported violations and I would have to appear in district court to answer to the charges.

One Saturday I went for my regularly scheduled visit carrying goodies and wrapped presents for the children, and everyone was gone. No one was there. They had disappeared without a trace. No word, nothing.

I was tortured and terrified, unable to eat or sleep, thinking the kids had met with some ungodly danger. Two weeks passed and I got the first phone call from Chicago.

Ed told me the children did not love me, that they had a new mother and Ciao, Baby. He didn't allow me to talk to the children. I didn't know if they were okay or even if they were with him. Every day was difficult.

Another week passed before Ed called again, this time from Washington State. He still would not allow me to talk to the children. He claimed they never even asked for me. He ordered me to send child support through his mother or the children would be homeless and hungry. He said if I tried to find him, he would disappear with the children forever.

I began to pay child support again, but this time I paid it to the Department of Human Services in the hopes that I would have documentation if I needed it. I continued to fear for the children's safety.

I received a summons to appear in district court on the alleged violations of a protection order, which was a blessing in disguise. It was the vehicle I needed to get in front of the same judge that had granted Ed his order. It allowed me to tell my side of the story, and the judge began to have doubts. There wasn't anything that could be done however until Ed returned to the State of Maine.

But good old Ed came home for Christmas and called from his mother's house in Maine. He finally allowed me to talk to the children. They had missed me and wanted to see me soon, as soon as possible.

Now that Ed was back in Maine I could get a court order, and with the sheriff department's help, I was able to retrieve my children.

We were all grateful to be together, but I knew we were not safe. So we moved into the battered women's project emergency shelter until the full hearing on this new protection order.

It immediately became apparent that the children had been severely neglected and abused. They looked terrible, much like prisoners of war, and they had bruises on their bodies.

I got help for them at the Aroostook Mental Health Center in hopes that they could begin to heal. I took them to a pediatrician with grave concerns for their well-being. I began to have a sense of dread that they had been severely abused, but I wasn't sure how.

The doctor dismissed my fears, claiming their behaviors were typical. The abuse I had suffered was not considered of concern to the children.

At the full hearing, another axe fell. The judge said that I could continue to have custody of the children, but I must reside in the emergency shelter for battered women for the next 4 months until the next scheduled hearing.

No one had ever been court ordered into the local battered women's shelter. I was stunned and felt punished by the court for acting to protect my children.

The judge also ordered a 2-hour supervised visitation for Ed. The children were court ordered to visit with their abuser. I prayed the visits would not interfere with the positive steps taken to give the children a sense of security.

They were reassured that he would not take them away and that he would not hurt them. They were both very brave, but I could still see the fear in their eyes. It made me even more determined to win this battle. I stayed in the shelter and I was grateful to have my children and believed things would work out someday.

The children continued to disclose stories of physical and sexual abuse. Their fears of their father, their nightmares and their daily needs were difficult, but we kept trying and we kept our faith.

I had to combat my own fears of Ed and maintain contact with support systems, even though doing so was an additional hardship. I worked daily with not falling into old but familiar patterns.

Round two in the court finally arrived but was continued again. Ed got another 2 hours' supervised visitation and the children were again set back by the trauma. I was allowed to leave the shelter to start a new family, on a farm, in a new town, with my loving partner. I was filled with new hope and joy at having my family together.

There were still obstacles to face, but I continued counseling for myself and the children, traveling 40 miles twice each week. I also took courses in self-esteem, assertiveness, and parenting classes.

Getting everyone healthy became a top priority and a full-time job. I traveled four times each week for 5 months with my husband staying home to care for the house and family. We were all beginning to heal. As we talked to the therapists and the guardian ad litem, they began to listen and were on our side.

They believed it was in the best interest of the children not to see their father, not even supervised. But the court hearings dragged on for another year, another year of not being able to promise the children they would be safe and secure.

Then on January 27, 1994, 3½ years after first seeking protection in the State of Maine, the children and I were set free, free from the control of our abuser, and it felt like a miracle.

Senator Cohen, children who grow up in homes where there is domestic abuse are abused children. I can make peace with the abuse in my life, but I am unable to do that for my children.

Women involved in abusive relationships need easy ways out with their children. They need to be supported by their communities, their States, and their Federal Government. Life should be easier without an abusive partner. We must stop making getting free so difficult.

If the Violence Against Women Act had been in existence, Title 2, Safe Homes For Women, would have helped me. A Federal remedy for interstate crimes of abuse by partners who cross State lines to continue abuse might have helped my children, might have helped me. Each State honoring the protection order issued by other States might have helped me.

The advocates at the battered women's project were the only people who believed that the abuse I suffered at the hands of Ed was also abuse suffered by the children. Witnessing the abuse never put the children in enough danger to get an open child protection case with the Department of Human Services.

By the time the disclosures of sexual abuse were aired, I had taken major steps without the help of the Department of Human Services or their resources.

I don't know what would have happened to my children if the battered women's project had not helped. Pine Tree Legal Assistance provided me with a free lawyer, Sarah LeClaire. They never wavered in their efforts to tear down the obstacles that were interfering with the safety of the children and myself.

Battered women and domestic violence projects nationwide need adequate, consistent, reliable resources that will help with intervention and prevention.

Senator COHEN. Thank you very much, Roberta. I'll ask you a few questions in a moment, but first we will hear from Grace.

STATEMENT OF "GRACE," VICTIM, OF PENOBSCOT COUNTY, ME

GRACE. Good morning.

Senator COHEN. Good morning.

GRACE. When members of my Spruce Run group were first approached about this hearing, I felt that because of my age and the duration of my marriage, my input might be helpful. I was married in 1955. A divorce is pending after 38 years of marriage.

At the age of 60, it is frightening to think of beginning a new life and, while my situation is perhaps not a typical one, my fears were and are very real. When a man uses his physical strength against a woman, it should never be considered acceptable behavior.

My husband and I were hired as caretakers of a small island off the coast of Maine. We went there in 1985 and I left in July 1993. While the verbal and emotional abuse were present almost from the beginning of my marriage, the physical abuse began less than 6 months before my departure.

I had become aware of my husband's involvement with another woman but for many reasons thought I could tolerate the situation. However, in February 1993, without being provoked, he announced that he was going to shoot me.

I have a hearing impairment. He had spoken to me and I hadn't heard him. He decided, since I couldn't hear him, that I should not talk to him anymore. "I should kill you. That's what I'm going to do. I'm going to shoot you." He then dressed his feet, left the house, went to another building and returned with a revolver.

He stood 6 to 8 feet from me and said, "You speak to me again and I'll shut you up for good." I could not leave or call the police because we were a mile out in the ocean.

The island is accessible only by private boat. There is no ferry or mail boat. I could come and go only at his discretion, and in this way I was truly isolated. We were alone on the island from October through May.

The verbal abuse increased drastically but the physical assault did not happen until early June when he choked me. Again, I had not provoked him.

It was on Father's Day that he became aware that I knew about his affair. I also was convinced at that time that one of our daughters knew about the affair and encouraged it. They maintained that I was paranoid and had fabricated the girlfriend. They began to plot to have me committed to a mental institution.

From then until I was able to leave on July 25, there were many quarrels with more choking and physical assaults. During one of these quarrels I sustained an injury to my thumb which required suturing.

When I returned to the emergency room 2 days later for wound dressing, this daughter and a son were there. This son had not been involved until this time. He lives 200 miles from the island. He was misled by his father and sister.

My husband had requested that I be committed for psychiatric evaluation. I spoke with the doctor, a nurse and my son at length and the picture became clear to all of us. I have a copy of the emer-

gency room report with me today verifying this and will enter it into the record.

It was at this time that I showed the doctor the bruises on my chest and rib cage, and he gave me phone numbers for Shoreline for Crisis along with an emergency hotline for domestic violence. The doctor also advised me to get a protection from abuse order, but I did not. My own physician and attorney advised me to do this as well.

I still ask myself why I refused the protection from abuse order. I think part of me wanted to believe that someone whom I had loved deeply and to whom I had devoted most of my life wouldn't harm me.

I returned to the island and left the following Sunday for the last time. My two sons took care of the physical moving and secured an apartment for me in Bangor. I was threatened once on the phone after I came to Bangor.

One thing I want to share today concerns the health care coverage for one in my situation. We had Blue Cross/Blue Shield with the State of Maine with group coverage. It's a good plan, and we've had it a long time.

One of the reasons I stayed in the marriage these last years was my concern about health care coverage. I have hypertension which can have serious side effects such as heart attack and stroke, and this worried me greatly.

But I learned from Blue Cross/Blue Shield that there's a program called COBRA under which the spouse of a subscriber can be covered for 3 years following divorce at a cost of $209 monthly. I will have the same coverage as before including prescriptions. However, after 3 years one must go on an individual plan with coverage dictated by what you can afford.

In my case, I will have 1 year after the 3-year period before I am eligible for Medicare. I'm fortunate to have the coverage and the option, but there may be others who would have more than 1 year on an individual plan. It would be beneficial if the COBRA program could be extended to cover a longer period. It would make the transition less stressful.

The other thing I would like to emphasize is the importance of Spruce Run and the significance that it has had for me. When I came to Bangor last July, I knew only two or three people. I did not know the area well. Spruce Run had been suggested by a friend. I knew it only as a program for battered women.

I called the first week I was here, attended the next meeting, and I have missed only two since. It has been extremely helpful to me, and I see all that it provides for others, mothers with young children for example.

We share a common bond. We have all been hurt by someone we love. I cannot adequately express my gratitude to this group of people who try to console and assist others while dealing with their own pain.

Thank you, Senator Cohen, for your concern about health care. Thank you for focusing on domestic violence. And I'm sorry.

GRACE. Don't be sorry. Thank you, Grace, for coming and sharing this story.

Senator COHEN. Sharon.

STATEMENT OF "SHARON," VICTIM, OF PENOBSCOT COUNTY, ME

SHARON. I was a 26-year-old woman with an 11-year-old child when I got with my abuser. I have been independent and considered myself a strong person.

Within a month of moving in with him, the emotional abuse had started. Within 3 months of living with him, I was in the hospital for 3 days for what the doctors determined a possible ulcer. That was really from stress. I was never questioned, never asked what led up to it, what might have caused it, never asked anything.

When I came home from the hospital, things got worse. If I disagreed on any point on anything that was said or we got into an argument of any type, he would take the telephone. He would take the fuses out of the fuse box, leaving my daughter and myself with no electricity. I was in the middle of nowhere.

Senator COHEN. Where were you living at this time?

SHARON. On Mount Desert Island. The man had a reputation of being a violent, intimidating person. Everyone in the community was well aware of him.

Shortly after this point the physical abuse started. My 11-year-old daughter had a golden retriever that she had had since she was a small child. She had just gotten him back from her father after a long separation from him.

When the dog tried to come to my aid during a particular beating, he threatened to kill the dog. Within a week, the dog was gone. He made us take him to the SPCA instead of returning him to my daughter's father where she could at least see him.

Shortly after this he convinced me that my daughter needed counseling. At the time she was 11 years old, and she thoroughly resented this man and the violence that was going on. He laid it onto the fact that she didn't want me with anybody. She wanted me for herself.

I put her into counseling to try to deal with the issues, and the only issues that I ever got were the things that she was doing wrong.

All this time I was cut off from my friends and family. If someone came to the house, whether it be a friend or family member, he would be so mean either to them or to me that they wouldn't come back.

He insisted he have the say in how I reprimanded my child, and if I let her go anywhere without his permission I would get beat. If she went up town with friends and he didn't know where she was, when she got home he would beat me and she would have to watch.

He would take me to cemeteries and make me get out of the car and take his loaded gun and tell me that I wasn't going to live to get out of the cemetery and because he didn't like the type of person I was. I was outspoken and I voiced my feelings.

There were times when I went to the doctor's with bruises or fractured bones, but I was never asked where they came from. Whatever excuse I used was let go. I was never questioned once.

It's a small community, and everyone knew what was going on, I'm sure, but I was never asked. There was no help from police. When I called the police after a particularly bad fight, he was real-

ly drunk and he had threatened to cut my finger off to get my diamond, the police let him drive off to go to his mother's.

When I asked the police who was going to be on duty when the night shift ended and would they please notify them of the potential for him to come back, they told me no one came on duty when they finished, that the officers were only on call due to a funding shortage.

I had no phone. I had to rely on pounding on a neighbor's wall for them to call the police. I said to the officer, "By the time I pound on my neighbor's wall and they call the dispatcher, he's going to be inside the house already before you ever get a call to get dressed to respond." I said, "I have no weapons here. The only thing I have is a hammer. But if he makes it through the door, that's as far as he'll make it."

The officer's response to me was "It sounds like self-defense to me, ma'am."

This man was a 250-pound man who had lived all his life brandishing guns to intimidate people, and the officers were well aware of him. They were as intimidated by him as I was.

The next day I had an officer call me and ask me if everything was okay, had he come back in the middle of the night, had anything happened? That was the only response I got from an officer. I never bothered to call them for several years again.

My daughter—things got worse. If I was on the phone, he would stand outside and listen to my conversations or he would go down in the basement and listen. I never felt like I could say anything that wasn't being overheard.

My daughter was starting to develop stomach problems, and she was at the doctor's at least every 2 months for the following 6 years. They laid it onto nerves, stress, problems in school. Never could we pinpoint an actual cause for the problems.

There were times when the knives and guns would be pulled out and I wouldn't even know why. I had been cooking dinner and maybe it wasn't done on time, and I'd have a gun to my head. My daughter witnessed all of this.

He always said if I called the cops, when the cops left, I'd be dead when they left. I believed him. When I did try to leave, he would threaten and intimidate anyone who befriended me. He's gone to friends' houses with guns, pulled in their driveways, threatened to shoot them. No one ever dared to call the cops. Everyone knew him and everyone knew he might go through with it.

He made a point of getting something on everyone who came in contact with us, something that they didn't want anybody else to know. All of my family members, any friends that we had, he always made it a point to know something about them so that if they tried to befriend me, he would have something to use against them. I knew this.

Finally, after 8 years, I had enough. We had built a business together that was in his name only. I had worked a hundred hours a week, 8 months out of the year, and never received any pay, never had any money in my pocket. If I had to go to the store, he calculated how much I needed and would give me that much.

I decided to leave. My oldest daughter had already graduated high school and had gotten married. My abuser and I had a 5-year-

old child together. I took her and I went to my sister's house and vowed never to return.

I knew I was leaving the business that we had built, and that was all I ever wanted out of life, was to be a small business owner, but I knew that no matter what happened, it was better than being there.

I left. I went to a local restaurant and applied for a job, and they hired me. I didn't think they would. I didn't think I had any talents to give them. I had been beaten down so bad that I didn't even think I was competent to work for someone else, but I did.

Within a week they had given me a dollar an hour raise and were quite happy to have me there. My abuser would have no part of that. I wasn't working at his restaurant anymore and he had to pay somebody to replace me.

He came to my job. He wanted to pick our 5-year-old daughter up first. He came to my job, threatened to cause a big scene, threatened to come in with a gun.

So I left. I went to my sister's house, very upset, didn't know what I was going to do. She asked me not to go to court, not to get a protection order because she knew the violence would be worse. This man didn't believe in the legal system. A protection from abuse order would do no good. So I didn't.

But my business, the restaurant I was working for, did believe in the legal system, and within an hour they called me and asked me to come back to work. They had had the police notify him he was no longer allowed on the property.

I felt safe there. I went back to work. I was determined not to go back. I was trying very hard to find a place to live for my daughter and for myself but to no avail.

One day when I got out of work, I went to pick my daughter up at his restaurant, and he refused to let me have her. He had his 14-year-old son restraining her in the kitchen so that she couldn't get to me.

I lost my temper. By this time I had become almost as violent as he was. I lost my temper and I started breaking out windows to try to get in to get her. His response was to come at me with a gun and told me he would shoot me if I tried any further.

That didn't stop me. I broke another window. I finally left to call the police and so did he. When the police came, they came and talked to me. I was at a different spot. And I told them I needed my daughter, that she was crying and trying to get out to get me. They said they would go talk to him and they would bring my daughter back to me.

At this time my sister came and she had stopped at his restaurant and he had taken a gun to her also and told her to leave the property. The officer questioned us both on this, and I told him he had taken one to me and threatened to shoot me too.

He went down to get my daughter. What he came back with was an order for me not to return to the premises that night and no child. He left my 5-year-old daughter there with this man all night and told me if I had a problem with that, that I could go to the courthouse the next day and maybe get a protection from harassment order but that if I went back there that night to try to get my child I would go to jail.

I was at the courthouse at 5 o'clock the next morning. At 8 o'clock he pulled up beside me and told me that if I went in to get a protection order, he was going in to contest it.

I didn't have enough faith in our legal system to go in that courthouse that day and I wanted to protect my daughter. I went back. I didn't want to be there. He knew I didn't want to be there. Things got a lot worse.

For 2 years I stayed there. I knew some day I would leave but I knew I had to have a plan when I did. And then my oldest daughter came to me one day and I had been——

Senator COHEN. This is the 23-year-old?

SHARON. My 23-year-old. I had been having my grandchildren for visits, and she wouldn't let me have them anymore and I couldn't figure it out. She kept making excuses. She said they were sick or they were busy or something.

Finally I went to see her one day and she just point-blank told me that this person had been molesting her for the last 10 years of her life. I didn't know what to do, but I knew I couldn't just leave haphazardly. I went back home. I stayed for 30 days.

I contemplated killing this man every day for 30 days, and I feel so grateful that when I picked up the phone to call Spruce Run, that they were there for me. They offered my child and myself a safe place to go so that I wasn't put into that situation.

We went into shelter. I got my protection from abuse order. The judge did believe me. He gave me custody. I couldn't get any help from the Department of Human Services because I called them and reported this after I went into shelter, not before I left my home. I had to fight very hard to find protection for my 7-year-old daughter, and I was too scared to fight.

What I did not know until after I got to Spruce Run was that, when I went to the hospital that very first time after 3 months, my abuser had told my 11-year-old daughter that I had a nervous breakdown and that it was her fault and that if she told me things, that I would end up back in the hospital again.

He also told her if she ever told me what had happened, that he would kill her and me too, and she grew up believing this. Anytime she refused, she would see a gun held to my head. She would see a knife held to my throat.

My daughter had the same doctor from the time she was 3 years old until she was 23 years old. She displayed all the classic signs of a child that was being sexually abused but was never asked a question, was never given the opportunity by someone who should have known what these symptoms were.

She had complete faith and trust in this man, and I firmly believe that had she had the opportunity or been questioned that her life might have been different. But not only that, when she did finally get strong enough through counseling to come to me and tell me what had happened, and I did leave and she was going through a stressful time, she went back to this doctor and his response to her was "Why have you waited so long to come out with this?"

My daughter has lost all faith in doctors to this day, and had this doctor asked my daughter or questioned my daughter, my 5-year-old might not have been sexually abused by my abuser's son. I

think that the medical profession really can have a lot of input if they asked questions when it's hard to ask these questions.

Today I volunteer for Spruce Run. I have complete faith in them. Without them, my daughters might not have a mother today. They might have to come see their mother in jail because that was the only way I could see to get out.

I have made a big difference in my life. I have worked hard to make a better life for my children. I have tried very hard to make a better life for people out there, for women and children who are getting abused, to give them the education that they do not have to be treated that way.

Spruce Run has done more for me than any agency could be asked to do for a person. Without them and without their support, I would never have gotten through the legal system and gotten through the trials that we had to go through.

I am now in school full time. I have gotten to counseling. I have gotten help for dealing with the violence. I have gotten help from being a violent person.

I'm a client member of the board of directors of Pine Tree Legal Assistance in the hopes of trying to be able to make sure that people that have no funds and no resources get the legal aid that they need to be able to stay out of these situations.

And I just really feel that if the medical profession had been there for my family, my children might not have gone through 10 years of abuse and neither would I.

Senator COHEN. What happened to your abuser?

SHARON. He's spending 12 months in jail.

Senator COHEN. For what?

SHARON. For molesting my oldest daughter for 10 years. And he'll be out in about 8 months and 20 days.

Senator COHEN. Sharon, thank you very much, Roberta, and Grace. I think these stories are poignant and compelling, and I suspect not at all unique.

One of the things that we're finding, as we lift up the cover and look into the subject matter of domestic abuse is that this is more common than any of us would like to admit, and perhaps by virtue of this very commonality more dangerous toward society than any of us have come to appreciate.

Roberta, I think that you summed it up very well when you said that any child who grows up in an abusive home is also abused. When you see men and women who are in an abusive relationship, that has to filter down to the mindset and have a tremendous impact upon the children themselves.

Also, many men ask the question: why do women stay in these "abusive relationships?"

Each of you has given a very simple reason involving a whole complex set of issues. Part of it, oddly enough, is love still for that individual. Most of it is fear.

Particularly Roberta, Grace, and Sharon, I suspect Sharon to a lesser degree perhaps, but there is, number one, the physical isolation. The more isolated you become, the less communication you have with anyone else, the less opportunity to communicate the nature of your situation.

That's one part of the fear. Second, the fear that "if you say anything, I will kill you." That also is a major aspect to it. Third is the fear of going to the police or to the court system because historically there has not been enough attention or sensitivity on the part of our judicial system to what is called family matters.

I was intrigued, and without offering any commentary on the very famous O.J. Simpson case today as to whether he is innocent or guilty of the charges, what struck me deeply was his statement when he was summonsed back in 1989—when his wife was beaten about the face and had bruise marks on her throat—his statement was "This is a family matter, and we can take care of it on our own."

There has been this notion over the decades that relationships between married people or unmarried people are a, "family matter," and the police generally have backed off and the courts have been less than eager to intervene and prosecutors have been, at least up until recently, not eager to prosecute those cases.

So there is a fear of breaching this reluctance to intervene and go to a court system or to the police. Further, these restraint orders are largely ineffective for the most part.

But assuming all of this, assuming you are able to summon up the courage to go to the courts and to seek legal relief, you have to win, number one.

In your case, Roberta, it seemed the evidence was turned just the other way around. First you have to win but assuming you win what happens then? The abuser may be a first-time offender as far as the court is concerned. They may suggest probation, or that you try counseling, and then you're right back in the relationship again.

And so fear, I think, is a big part of it. There is also the financial aspect that each of you I think has been faced with. What do you do about surviving?

I don't know the nature of how you came to be compelled to support your husband, Roberta, or what his disability might have been that allowed a court to impose that kind of burden upon you. But ordinarily women who have been raising children have either given up their own pursuit of a career, or have not developed the skills that are necessary to compete in a world that's changing very rapidly, and so you find yourself suddenly without any support mechanism, and very few skills that you can market and survive on.

So you have all of these factors that are mixed into it. But that's really not why we're here today. We are really here to talk about the health care system in terms of what the medical profession can do and ought to be doing and perhaps ways in which we can enlighten the medical profession to start asking the right questions.

And that is something also that, Sharon, you mentioned, and Roberta, you mentioned. I was curious, Roberta, during your testimony, you didn't indicate whether or not you were physically battered, whether or not when you went to the hospital they asked you any questions about the nature of your injuries. Were you battered at times by your husband?

ROBERTA. Yes. Yes, I was. Many times I received substantial injuries such as dislocated shoulder and a broken nose. But one particular time that I did seek medical attention was I had a lacera-

tion over my eye that had swollen my eye shut, and I went to the doctor and told him that I had walked into a door.

My abuser was with me at the time, and the doctor asked him to leave the room. And the doctor asked me, he said, "It looks to me like you have been hit." And I told him no, that's wrong. And he didn't pursue the matter any further.

Senator COHEN. Had he pursued the matter any further, would you have told him something differently or were you too frightened to tell him the truth at that time?

ROBERTA. Well, at the time I was very frightened because my abuser was towering over me. He wouldn't even allow me to go to the doctor by myself. But had the doctor offered me some assistance or some hopes such as mentioning the battered women's project and the assistance that they offer or protection order or something like that, if I had been aware of these things, then maybe I would have changed my answer.

Senator COHEN. When you had the broken nose and the broken or dislocated shoulder, did you seek medical treatment for that?

ROBERTA. No, I didn't. I was too embarrassed to go to a doctor.

Senator COHEN. And so your recommendation would be that whenever a woman or male but predominantly women are abused by their husbands or boyfriends, that they—what would your advice be? What would you tell them to do based upon your experience and living through this ordeal of yours?

ROBERTA. I would advise victims of abuse to seek help through their local battered women's project, through the legal system, to know that the abuse is not their fault and there is help out there.

Senator COHEN. And in going to see the doctor should they need medical treatment, would you recommend that they confide in the doctor, ask the doctor or perhaps the doctor should set a policy of interviewing and treating the battered individual alone?

Would you be able to overcome today, if you had to do it differently, that fear of telling the doctor what really happened?

ROBERTA. Yes. I wouldn't be so embarrassed if I had—if he had been more personable toward me and been more sympathetic. He just said, "It looks like you have been hit." And that was very embarrassing. But if he had said, "You know, there is help for people who are being abused," then I might have been more open to him.

And, yes, I would recommend that victims of abuse seek medical help and get documentation that is needed if they are going to prosecute their abuser.

Senator COHEN. Did either of—did any of you, Grace, Roberta, and Sharon, did you feel comfortable sharing this information with anybody else? Did you talk to—I guess on an island that you can only get to by boat, there aren't too many people you can share that with, but were you afraid of sharing information with anyone else?

GRACE. I wasn't afraid really, and I did speak with family members on the phone and I had family members who were very supportive, and my children. I had a meeting with two doctors, the emergency room doctor and my own regular doctor, the following week, a few days later. Talking about it was not a problem for me and I——

Senator COHEN. What were the injuries you sustained?

GRACE. I didn't have anything visible. There were no scars. My throat was sore from having been choked, and I had—the bruises that I did have were covered. I said, you know, the rib cage and chest area; no one could see that, and the threatening with the gun was very frightening.

But I certainly was not afraid once I did see the doctor to discuss what had happened because I knew I had to in order to leave.

Senator COHEN. Sharon, when you said your daughter exhibited all the symptoms of being abused, what were some of the things that indicated that?

SHARON. At the time I had no idea what the symptoms were, but this is just what I have learned since then. But she went from being a very petite, tiny child to becoming very overweight within a 2-year period. She missed an untold amount of school, always with stomach problems, never to be able to find anything.

She would wear layers and layers and layers of clothes to make herself look less appealing. She had a bad eating disorder. She would eat all the time. You knew she couldn't be hungry, but she would still eat. I think those are the biggest ones.

But this man had seen her for so many years and knew the situation that we were in and was well aware. He lived in the same community. I just feel like if he had asked some of those prying questions and not been so hesitant to ask, that she had enough trust in that man so that I really feel that it would have made a different outcome.

But let me just add one thing. The only help that I feel I did ever get medicalwise or my family got from a doctor was that was where I picked up the card for Spruce Run. That was laying on the counter as I came out of the office one day from taking my youngest child to the doctor's, and I just stuck it in my wallet and left it there.

Senator COHEN. You also indicated that there's no question about the bruises that you had sustained and yet no questions were asked?

SHARON. None.

Senator COHEN. You didn't feel ready to divulge at that time, Sharon?

SHARON. I was too embarrassed. When I was in the hospital for that 3 days, he came in twice and caused a scene because they wouldn't let—they weren't ready to let me out of the hospital and was verbally abusive and emotionally abusive.

He called the nurses on the phone at 11:30 one night because they wouldn't put him through to my room. And no one questioned me then either.

Senator COHEN. Well, I want to thank all three of you for sharing these experiences. They're harrowing. It's been a torturing experience for all of you, but I think it's very, very important that you come here today to lay open these stories because, as I indicated before, I think that they are not at all atypical of what many, many, thousands and millions of women across this country must endure on a daily basis.

When we start looking at the numbers, as I quoted in my opening statement, 65 people a day die from violence, 6,000 being injured. You start totaling those numbers up and what it means to

this country and what happens, not only between the spouses or friends. It also shows what's happening to the children and their mindset. I think it becomes very clear that children who grow up in that kind of environment are going to have some serious problems associated with their own selves in the future. And perhaps you can see that a repetition of the abuse would take place.

So I want to thank the three of you for coming forward. Your statements have all been entered into the record, and, Grace, anything you want to submit for the record to verify——

GRACE. Yes.

Senator COHEN [continuing]. What has taken place in your situation will be included, and I will be sharing this information with all of my colleagues on the Aging Committee and also on the Judiciary Committee.

As I indicated before, the provisions dealing with violence against women are now part of the anti-crime legislation which is now in conference, and Senator Biden has been very supportive in joining me in this effort to see to it that we start addressing this very, very serious issue. Thank you all for coming.

GRACE. Thank you for allowing us to do this, sir.

[Recess.]

Senator COHEN. Our next panel consists of four distinguished individuals. The first panelist is Dr. Robert McAfee, previously known to us as an unassuming South Portland surgeon. He is here today in his new capacity as president of the American Medical Association.

I understand that his "coronation" took place in Chicago last week, and I am sorry we were not all there to help celebrate that moment with you, Bob.

The AMA, I think, is very lucky to have him at the helm, particularly as we attempt to navigate some very difficult waters with health care reform.

I am particularly grateful to Dr. McAfee for his outstanding leadership on this issue. Under his leadership, the AMA has launched a major initiative to prevent family violence by increasing physicians' awareness and knowledge regarding the diagnosis, the treatment and the prevention of child, partner, and elder abuse.

As part of this effort, last month the AMA awarded a $9,000 grant to the Maine Coalition for Family Crisis Services to develop physician and patient educational materials on domestic violence.

Dr. McAfee testified at a similar hearing on violence against women held last year in Portland, and I am particularly pleased, Bob, that, given your busy schedule, you are able to be with us too here today.

Also joining us is Dr. Eric Brown, the faculty physician at Eastern Maine Medical Center Family Practice Residency Program.

Dr. Brown first became interested in this issue when he spent some time working on the Indian reservation here in Maine, and he has since focused both his studies and his teaching on the subject of family violence. We welcome you, Dr. Brown.

Next on the panel is Nancy Fishwick, a family nurse practitioner and assistant professor at the University of Maine School of Nursing.

Dr. Fishwick has done a good deal of research and writing on domestic violence in rural areas and is also responsible for integrating domestic violence into the curriculum for students in the nurse practitioner program at the University of Maine. Dr. Fishwick, we welcome you.

Finally, we have Robert McLaughlin, a counselor and Chair of the Health Care Response Committee, Maine Commission on Domestic Abuse. Mr. McLaughlin has worked on a number of battered women's support groups as well as the family violence project in Augusta and the Maine Coalition for Family Crisis. Bob, welcome here today. I thank you all for appearing here today.

Will you begin, Dr. McAfee, please?

STATEMENT OF ROBERT McAFEE, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION

Dr. MCAFEE. Thank you, Senator, and I appreciate very much the opportunity to appear before you today representing the American Medical Association, 300,000 physicians now, the largest group of physicians in the world. I hope each and every person from Maine in this room took some vicarious pleasure in my inauguration as AMA president last Wednesday evening, the first time anyone from Maine has had that opportunity in 147 years of our existence.

I couldn't help but also think as we looked at our panel classification that indeed all of us are victims of this problem. I congratulate the first panel for their courage and their presentation.

America is indeed at war with itself. We, the people of the United States of America, in order to form a more perfect union, will manage to kill this year 26,400 people by homicide, 13,220 of them by handgun homicide. The next nearest country to us is Canada which will kill 125, Japan 66 and, yes, we 13,220.

The largest cause of death, the single greatest cause of death in males in this country, both African American and Caucasian, between the ages of 18 and 26, is homicide.

And we, the people of the United States of America, in order to defend our right to bear arms, will allow tomorrow 100,000 children to go to school in this country with a gun.

And we, the people of the United States of America, in order to assure domestic tranquility, will allow more women, as you have heard, in this country to be killed in their homes, in their homes, by those who theoretically love them the most, their husbands and boyfriends, in a 10-year period, more women in a 10-year period than men died in the Vietnam War.

A conference I attended earlier this year pointed out graphically to me for the first time the number one cause of death of women in the workplace in this country is homicide, and it's not that the workplace carries with it unique opportunities.

I'm afraid it's the domestic violence agenda playing itself out in the workplace. So it's not industrial accidents. It's not toxins. It's 41 percent of those women in the workplace being killed again by those who know them.

One asks why the American Medical Association is involved in this, and I think you have heard from the first panel why we need to do a better job than what we're doing.

When you ask victims of domestic violence, 87 percent of them say, "We would rather have been able to tell our physicians of the ongoing repetitive behavior in our homes than anybody else."

That's slightly more than want to tell their priest, their pastor, their rabbi. It's 20 percent more than want to tell the police. And then given all that responsibility, how good a job do we do? Well, probably less than 10 percent of the time when we have the opportunity to make a diagnosis of spousal abuse or family violence do we do it.

We tend to focus on the twisted ankle, the broken nose, the cracked ribs; and we accept the first time when we ask that question, "It looks like someone else may have caused this," the patient says, "No. I fell downstairs." "I bumped into the refrigerator."

Well, we have got to do a better job, and that's what I think we can bring to the table in this discussion. For 3 years now we have been able to initiate a program which now has a physician coalition in excess of 8,000 physicians all across this country who have made a commitment to intervene in family violence.

And before anyone says, "That's a marvelous accomplishment, Dr. McAfee," I remind you I do represent 300,000 physicians. So we do have a considerable way to go.

The protocols that we have established should overcome the concerns that many physicians have about opening Pandora's box, how you can, if a positive response is obtained, then be able to refer that individual to the most appropriate resource in your community.

Being part of this coalition also gives you, in a kit we send to every physician free of charge, a poster which we hope you'll display in your reception area which indicates that violence is a public health problem; second and more poignantly, a smaller certificate to which you append your name that goes in your examining room so that as your patient is sitting there looking at the wall, he or she—because 10 percent of victims are men—he or she, by looking at this, says: "I, doctor so and so, am a member of the physicians' coalition. I understand that family violence may play a significant role in your health. And if today family violence in your life is a significant problem, I wish you'd take the opportunity right now to tell me about it."

And I think that alone, creating that environment, has been very helpful in making many patients feel that "perhaps this individual I can discuss this problem with."

I will share with you some of our successes and some of our problems. Three years ago, chatting with the editor of the Journal of the American Medical Association, I said, "I think the time has come for a theme issue on family violence."

He said, "To do that I need 8 to 10 peer review articles. I'm not so sure I can get them."

He put out a request. Within 2 months' time he received 122 manuscripts, of which 88 were accepted on peer review for urgent publication, not only one but two issues of JAMA, the world's most widely read weekly medical journal published in 17 countries and 7 languages.

And in addition, every specialty journal of the eight that we publish every month were totally devoted to the problems of violence

in our society, and each of those papers has now been put in a single volume which I will leave with the Committee today as a resource document. From this I think we can build greatly.

Second, I would be remiss if I did not point out the excellent response that I have achieved, not I but the program has achieved, across this country by State medical associations or the auxiliary of each of those associations.

I have just come back from one in North Carolina, and I'll leave this document with you, which I think shows what can be done at relatively low cost.

Many of the publications out there can be freely duplicated, bound together, can be localized or made statewide by the individual States and their resources and serve as a major resource document not only in terms of education but in those places of important telephone numbers, those resources, the solutions which we think lie there.

One of the very successful publications which hopefully we'll find coming into Maine soon is a coloring book. It's put out by our Alliance, the new name for our auxiliary across this country. It's designed for immediate preschool and kindergarten age children.

It is called "I Can Choose," and it's an attempt to point out to children that, when given conflicts, when given the fact that Johnny pushes you off the slide, there are ways to react to that other than pushing Johnny back. And you pick your choice. You put in a smiling face or a bad face, depending upon what you think is the best way to go.

It serves as a teaching tool for children, but more importantly it helps identify for teachers and others those children that already are so ingrained to accept violence as part of their life preschool, that we need to concentrate our efforts in that child at this time.

And we are hopeful that each and every child in this country will have access to this as a beginning series of coloring books which are in essence educational materials in that regard.

The National Conference on Family Violence: Health and Justice, cosponsored by the AMA and the American Bar Association was a very significant event this past March in Washington, D.C. It attracted five Cabinet members. The Clinton administration was obviously very supportive of this.

We had hoped to limit this to 300 working, a working conference for 300 experts in this country. We were forced to accept 440, which I was delighted because they all had the credentials. They all were experts. They all had done something very significant that we needed to share.

The three 5-hour work sessions of this 2½ day conference dominated this exercise. We turned away 440 people who wanted to be part of this conference. From that have come the recommendations of the 10 work groups, and I will leave a copy of these with you today, because from those will come a new structure, a new organization.

Many of these lend themselves to legislative research if not legislative solutions. And I offer these to you as a beginning of a coalition between the health and the justice communities as we look at family violence in this country.

I will tell you that the focus has to be on prevention. We don't do very well in the adolescent years when violence is so ingrained in our society. We need to be focusing our precious research dollars, our precious educational dollars at the preschool and early school children to help identify nonviolent ways in which one lives one's life.

To do this, we have got to overcome a great number of influences in our society, sometimes the lack of influences in the home situation that may be and should be directing that child.

But we can incriminate the television industry and the motion picture industry, as we have in a report coming from the AMA's annual meeting last week, the most major report written to date on the mass media's effect on violence, which hopefully will also be a part of your agenda.

It recommends for the first time that the PG rating, PG–13 rating of motion pictures are not enough, that we need to know at age 3 to 5, at age 8 to 12, the more impressionable impact that such movies may have on children at those ages.

We need to ask the industry to continue to be a part of the solution. We need to continue to ask the industry when the violence chip will be incorporated in the new televisions manufactured in this country, and I'm totally convinced that will happen relatively soon.

Certainly Congressman Markey's bill out of the House is one which I think will serve as a focus to begin to do that. This is not censorship. This is helping parents parent. Anything that we can do to allow particularly the single parent families to program out the exposure to violence as an accepted way in our society to live, and I think we will have accomplished some of that which we need to do.

I need not tell you that we, the AMA, have been very supportive, in terms of gun legislation. We no longer have a Brady bill; we have a Brady law. And that's the beginning, and from that I think we can begin to continue to identify policy for this country, which boils down to the responsible use of firearms and keeping them away from those who would irresponsibly utilize them.

You have heard from your first panel, each and every one of those victims, that guns was a part of their lives.

I make reference in my written testimony to the fact that this committee has a special interest and expertise in matters relating to the elderly. And we would like to specifically address this subject of violence perpetrated upon senior citizens at this time.

The major initiative of the AMA is focusing now on a report to our members involving this particular most neglected part of the aspect of family violence.

In providing medical care, I think physicians have benefitted from the wisdom to be gained from listening to and learning from the experiences of the elderly.

This is something to be treasured, and we are acutely saddened by the serious health effects of violence upon their lives. Statistics indicate that there are between 1 and 2 million cases of elderly abuse in this country each year, often within the family setting.

Violence in the form of elderly abuse within families not only has devastating effects upon the particular elderly person being abused

but also impacts upon the family structure itself, destroying the moral fabric of that family.

The AMA believes that we should be flattering, not battering, our elderly citizens.

I will finish, Senator, with three poignant comments that have been made to me over the 3 years that I have been involved in this initiative.

Forty percent of my time last year was spent, in my travel schedule of 220 days around the country, in dealing with and responding to requests pertaining to family violence. At a time when we are looking at major health system reform, you would think that would be dominating our agenda, and it is.

But one cannot separate the two. You cannot put a cap on health care expenditures in this country without putting a cap on violence as well. We are sick and tired of being sent the bill for violence in our society, at the same time expecting that we can control those costs without some societal commitment in all the areas that have an impact on violence.

The first comment I leave to you is that from Mark Rosenberg of the Centers for Disease Control. I have been appointed a member of the advisory committee of the Injury Prevention Division of CDC, which is the largest source of research dollars in violence that exists in the Federal Government right now.

We need to assure that that Division and CDC in general maintain its budget share if we're going to move ahead in this particular regard.

But Mark's comment to me was that violence, that years of life lost to violence in our society, is greater than the years of life lost to heart disease, cancer, and stroke combined, mainly because it is a disease, it is a condition of young people.

The second comment I leave you with is one which I share with all my colleagues. It was made at one of our very first media briefings on domestic violence. It was uttered to me by a 35-year-old cardiologist from Kenosha, Wisconsin.

He had established a marvelous battered women's shelter in that community. When I asked Kevin Fullen, I said, "I understand you're a cardiologist." He said, "yes." I said, "But I also understand that you treat battered women."

He said, "Yes, and so do you."

Senator I will tell you that if a woman calls my office and makes an appointment and a man calls later and cancels it, there's a 50 percent chance that that's a battered woman. That's an exercise that has been duplicated across this country and our physician colleagues are learning that if we don't flag those charts, if we don't take the opportunity to intervene when we can, we lose that very precious attempt to intervene when we should, as identified by your first panel.

And finally, I guess the most poignant comment was made in our very first press conference when we announced our domestic violence agenda in New York City 2 years ago. I was afraid we'd give a party and no one would come.

We had 10 television cameras in a room in a downtown hotel that morning. There were 100 members of the print press there in that room.

The Surgeon General was sitting there with us at that time. I was delighted, and I said so in my introductory comments. Every single women's magazine was represented.

When we finished, my joy was somewhat diminished by a very young reporter in the front row. I think she worked for Redbook. She came up to me and she said, "You should be happy with the response that you have received from the people who are here today, but you need to also look and see who was not here today. And you did not have in this audience a single feature writer from Sports Illustrated, from Playboy, from Penthouse, from Sports Afield."

Well, Senator, we're going to be in Sports Illustrated this week. We're going to be in Playboy. We're going to be in Penthouse.

Somehow or other, my joy at accomplishing that is not nearly as great as I thought it would be. It's important for us to continue to focus on public health and family violence and what we can bring to the table. And I thank you for the opportunity to participate with you this morning.

[The prepared statement of Dr. McAfee follows:]

American Medical Association
Physicians dedicated to the health of America

515 North State Street
Chicago, Illinois 60610

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Senate Special Committee on Aging

Presented by

Robert E. McAfee, MD

RE: Family Violence

June 20, 1994

Mr. Chairman and Members of the Committee:

My name is Robert E. McAfee, MD. I am a practicing general surgeon in Portland, Maine and President of the American Medical Association (AMA). On behalf of the AMA, I am pleased to have this opportunity to testify regarding the very serious issue of family violence and its related health care effects and costs. As physicians, we are deeply distressed by the volume of care that we provide as a direct result of violence in this country, including domestic and family violence.

Violence in this country today, in all of its forms, has become a major medical and public health epidemic. America today is a land of violence. It absolutely surrounds us in our society; we cannot run or hide from it, we cannot escape it. It is the made-for-TV movie glorifying murder or rape watched by our young children; it is the family bully savagely beating and abusing the spouse, child or elderly family member; it is the senseless, random drive-by shooting on far too many of our city streets or any other place where someone just happens to be in the wrong spot at the wrong time. There is no "set demographic" for violence; it is black and white; it is male and female; it is rich and poor; it is urban, suburban and rural. Violence is everywhere; it surrounds us.

We live in such a terribly violent society that violence in the United States has reached epidemic proportions. In turn, we also must address the reality that violence is a major medical and public health issue. In addition to having a severe, broad-reaching negative impact on the health of Americans, violence results in a huge and ever-growing number of encounters with the health care system. Care for the victims of violence strains the health care system and adds significantly and unnecessarily to the U.S. health care bill. This avoidable care is growing in prominence as a source of our nation's health care expenditures. It has been reported that over 500,000 emergency department visits annually are due to violent injury and that two-thirds of crime victims treated in hospitals are uninsured. It has been estimated that the direct medical costs of all violent injuries add more than $5.3 billion to U.S. health expenditures.

Over 2 million people in this country each year suffer from violent, nonfatal injuries. Each year, an estimated 50,000 deaths are attributable to violence in the form of homicide and suicide. To put this in perspective, our society repeats every year a Vietnam Memorial Wall of Death that is directly attributable to violence. The U.S. ranks first among industrialized nations in violent death rates. In fact, the number of deaths attributable to violence in this country each year is greater than the number of deaths attributable to any one of many horrible diseases and medical conditions--for example, HIV infection, tuberculosis, diabetes mellitus, chronic liver disease, breast cancer, leukemia, emphysema, viral hepatitis, nephritis, and heart endocardial diseases.

Violence in general is totally unacceptable, but particularly insidious and troubling is domestic and family violence in our society today. The prevalence of such violence is an absolute national disgrace. The following statistics are telling:

> Children: In 1991, over 2.5 million children were reported abused or neglected. Child abuse results in 1,400 deaths annually.

Women: Violence is the leading cause of injuries in women. 35% of women who seek emergency department treatment are the victims of violence. An estimated 12 rapes occur every hour. An estimated 2-4 million women are battered each year by their partners. 50% of women murdered in the U.S. are killed by their partners. 37% of obstetric patients are physically abused while pregnant. Women who are victims of abuse are more likely to abuse their children.

Elderly People: An estimated one to two million elderly people are abused by relatives and non-relative caretakers.

These sobering statistics clearly demonstrate that domestic and family violence in the U.S. is a major medical and public health issue.

The AMA and physicians have been, and continue to be, very active in efforts to address problems of domestic and family violence. In the past several years, we have undertaken a substantial number of activities in the area of family violence control and prevention. These activities are described in a 1993 Report of the AMA Board of Trustees (copy attached). Also, the AMA adopted in 1991 a report of the AMA Council on Scientific Affairs (also attached) that addresses violence against women and that initiated an AMA campaign to alert the health care community to the widespread prevalence of violence against women. Physicians see the results of violence far too often, and we must be sensitive to the needs of these victims of violence and help them to take steps to prevent repeat victimization.

On the subject of family violence, the AMA has published and widely distributed its Diagnostic and Treatment Guidelines on child physical abuse, child sexual abuse, domestic violence, and elder abuse. Additionally, on November 12 of last year, we testified before the United States Senate Judiciary Committee on the "Violence Against Women Act," at which time we expressed the extreme concern of the physician community over the detestable problem of violence against women in our society and supported the bill. Just last month, in a letter to Senate and House crime bill conferees, we reiterated our support for the provisions of this Act contained in the Senate-passed version of the crime bill.

Physical and sexual violence against women is at epidemic proportions, the social and economic costs to society are staggering, and we must take definite steps, such as those now under consideration in the crime bill, to get this major problem under control before more innocent people are victimized. We also expressed our support for the provisions of the "Child Safety Act" contained in the Senate-passed version of the crime bill, providing for the establishment and operation of supervised visitation centers. These centers could prove highly beneficial as a means of breaking the continuing cycle of abuse suffered by children during and after legal separation and divorce.

As the President of the AMA, I take pride in the fact that we have organized a national coalition of physicians against violence. Also, on March 11-13 of this year, we sponsored the *National Conference on Family Violence: Health and Justice* in Washington, D.C., which focused on how medicine and the law can work effectively together to address family violence.

We realize that this Committee has special interest and expertise in matters relating to the elderly, so we would like to specifically address the subject of violence perpetrated upon senior citizens at this time. In providing medical care, physicians have benefitted from the wisdom to be gained from listening to and learning from the experiences of the elderly. This is something to be treasured, and we are acutely saddened by the serious health effects of violence upon their lives.

Statistics indicate that there are between one to two million cases of elderly abuse in this country each year, often within family settings. Violence in the form of elderly abuse within families not only has devastating effects upon the particular elderly person being abused, but also impacts upon the family structure itself, destroying the moral fabric of the family. The AMA believes that we should be flattering, not battering, our elderly citizens.

In addition to elderly abuse, violence is visited on the elderly in the form of murders of elderly people, rapes of elderly women, and other crimes. Too often, the elderly are "easy targets" for seemingly random street crime and violence. Street crime and violence against the elderly has a negative effect both upon the family of and upon the particular elderly person against whom the crime is perpetrated; it also has an enduring societal effect, with the criminal's prosecution, potential incarceration, and rehabilitation exerting consequences in terms of contributing to overcrowding of prisons and increased demands upon the criminal justice and social services systems in this country. Violence against the elderly is tragic, both in terms of human costs to the victims and in terms of the economic costs to society.

We feel that the magnitude of elderly abuse, as well as street crime and violence against the elderly, goes beyond the description of extremely disturbing. To put it bluntly, this conduct is shameful and simply inexcusable in a society supposedly as civilized as the one in which we live. We must respect and protect our elderly citizens, and treat them with honor and dignity.

In conclusion, the AMA is strongly concerned about the family violence so prevalent in our society today and about the impact it exerts on our health care system. The issue of family violence has direct relevance to practicing physicians. It is the practicing physician who must treat the results of such violence. We have worked hard to bring about changes for the better, and we will continue to do so. Striving to effect a curbing of family violence is a major goal of the AMA. Just last week, characterizing family violence as a "centerpiece public health issue", our House of Delegates resolved to "continue its leadership role in bringing physicians and other professionals and their organizations into collaborative efforts to prevent and reduce family violence in our society."

Finally, if our efforts to achieve meaningful health system reform are to succeed, a major step must lie in significantly reducing the adverse health effects of violence upon our citizens, including the elderly. Thank you for affording me the opportunity to appear here before you today. I will be pleased to respond to any questions you may have.

B. VIOLENCE AGAINST WOMEN

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED:

The two decades since the 1960s have witnessed a new national awareness of the violence faced by women. Prior to the 1960s, only a few forms of violence -- such as assault or rape by strangers or casual acquaintances -- were seen as a danger to women. Families were assumed to afford protection against this danger, and women were advised to seek the shelter of their homes in order to remain safe from harm. The study of assaults occurring within families did not begin until the 1960s, with an emphasis on physical child abuse. At this time, there were almost no reports of sexually molested children or abused wives. Violence in the family was thought to be infrequent and to result from the psychopathology in the individuals involved, rather than being viewed as a society-wide problem with far-reaching consequences.

The new knowledge on violence against women began with the anti-rape movement which, in the 1960s, began to focus on sexual violence against women by strangers and acquaintances. Such discussions revealed the prevalence of women experiencing sexual assaults by intimate males, rather than strangers, and led to the identification of physical assaults of women by male intimates as a phenomenon of previously unrecognized proportions. Studies now document that women in the United States are more likely to be assaulted and injured, raped or killed by a current or ex-male partner than by all other types of assailants combined.

RELEVANCE FOR MEDICAL PRACTITIONERS

There have been earlier periods in U. S. history when the victimization of women and children became topics of special concern. However, the past two decades represent the first time that systematic data on prevalence and outcomes have been gathered or that responses have been so wide-ranging, involving advocacy, medical, mental health, criminal justice, governmental, and academic communities. Major research and police initiatives have been developed to address aggression occurring within families. Rape laws have been amended nationwide to protect victims; in some cases removing the exemption offered for assaults by husbands and ex-husbands. Nearly every state has established new legislation targeted for violence between adult partners, and federal legislation on violence against women is now pending. Although the medical community -- along with the criminal justice system -- is the most likely to see women victims, and thus constitutes a frontline of identification and intervention and although police and others in the legal community increasingly benefit from training and enhanced procedures in responding to women victims, only rarely are physicians and other medical staff provided with training or specific protocols to aid in dealing with these cases.

In summarizing the concerns of physicians and public health officials, attending the AMA National Leadership Conference, Surgeon General Antonia Novello, M. D., cited a Centers for Disease Control study reporting that violence by intimate partners is the leading cause of injury for women, "responsible for more injuries than car crashes, rape and muggings combined." Novello continued, "But sadly, the medical community has yet to consistently identify these women as victims and extend treatment beyond the physical manifestations of an abusive relationship" (Doctors Urged to Act in "Crisis" of Violence, American Medical News, March 4, 1991).

The cost of a failure to identify and intervene with violence, in terms of patients' suffering and the use of medical providers' time and resources, is incalculable. Particularly with violence by intimates, assaults tend (a) to be repeated over time, (b) to produce more injuries than assaults by strangers, and (c) to have complicated sequelae with implications for further morbidity (e. g., the possible victimization of another family member by the original abuser or victim). The long-term nature of the effects of trauma, the pattern of repeated assaults by assailants in families, and the frequency with which intimate assaults against women result in injury typically mean repeated contacts with victims, involving various medical personnel and services, with a low success rate for the alleviation of symptoms. Moreover, as Robert McAfee, M. D., Vice Chairman of the AMA Board of Trustees noted, "In addition to the terrible human toll, violence strains the resources of our health care system . . . When we are being constantly criticized about health care costs, this is one of the factors driving those costs up" (Doctors Urged to Act in "Crisis" of Violence, American Medical News, March 4, 1991).

OVERVIEW OF TOPICS COVERED

This report reviews the following (overlapping) forms of violence against women: rape, physical and sexual assaults by marital or dating partners, and the long-term effects of child sexual molestation in adult women. (Topics of child physical abuse and elder abuse have been covered more generally in other Council publications.) Empirical evidence on prevalence and the physical, psychosocial and emotional outcomes of these types of victimization are reviewed, relevance for the practice of medicine discussed and recommendations for enhanced identification and response presented.

RAPE

In traditional definitions, rape has been defined as the "carnal knowledge of a female forcibly and against her will." The meaning of "carnal knowledge" is restricted to vaginal-penile penetration; other types of sexual penetration are excluded. This definition is used by the Federal Bureau of Investigation (FBI) for its Uniform Crime Reports of offenses known to the police, as well as by the National Crime Survey (NCS) "to measure the extent of unreported crime in the United States. Although data on rape is gathered at the federal level, actual legislation on rape varies by state. In the last two decades, legal definitions of rape have undergone extensive revisions: many states now utilize expanded (or reform) statutes that define rape as the "nonconsensual sexual penetration of an adolescent or adult obtained by physical force, by threat of bodily harm, or when the victim is incapable of giving consent by virtue of mental illness, mental retardation, or intoxication." These reform definitions typically include other types of sexual penetration, in addition to vaginal, as well as attempts to commit rape by force or threat of force.

Incidence and Prevalence of Rape

According to FBI crime reports, a total of 92,486 rapes of women were reported to the police for the year 1988. Approximately 82 percent of these rapes were completed by force; the remaining 18 percent were forcible attempts. This yields a victimization rate of approximately 73 rapes per 100,000 adult women. Estimates based on the National Crime Survey, which includes incidents not necessarily reported to the police, are nearly twice as high: for 1987, the rate of rape victimization was 1.3 per 1,000 women and girls (excluding children under the age of 12) and 0.1 per 1,000 men and boys.

However, parameters of both the Uniform Crime Reports and the National Crime Survey exclude many incidents of forcible sexual assault. Only a small percentage of crimes are reported to the police. Significantly, officials consider rape to be the most underreported of all crime categories measured and, although the NCS is designed to tap the incidence of unreported crime, no specific equations regarding sexual assault are included. The single question to probe for rape asks, "Has anyone attacked you in some other way?" Unless a respondent volunteers information about sexual assault, no further questions are asked. Further, the context of a "crime" virtually guarantees underreporting of intrafamily assaults in both surveys. Marital rape has been exempt from rape laws in most states until recently, and still is almost never reported to police. NCS respondents may view assaults occurring between family members as personal problems, rather than as criminal actions. Further, NCS interviews are frequently conducted with other family members present and thus privacy in responding is not assured.

Epidemiological Studies. Prevalence studies using epidemiologic methods yield more reliable estimates. Such studies now indicate that at least 20 percent of adult women, 15 percent of college women and 12 percent of adolescent girls have experienced sexual abuse and assault during their lifetime. In a study using the California rape statute to define rape as "forced intercourse . . . or intercourse completed when the woman was drugged, unconscious, asleep or otherwise totally helpless and hence unable to consent . . ." and an intensive interview format, 44 percent of a random sample of women had experienced at least one attempted or completed rape. Similarly, in a community study conducted in South Carolina, 23 percent of adult women had experienced a completed rape (defined as nonconsensual penetration involving force or the threat of force), and 13 percent had experienced attempted rape. Estimates for African-American women are even higher. Again using a strict definition of rape and a detailed interview format with a community sample of women in Los Angeles, one in four African-American women, and one in five white American women, reported at least one incident of completed or attempted rape since their age 18.

Incidence figures (the number of new cases within a given time frame) add dimension to these findings. In a study of 2,291 adult women in Ohio, 28 per 1,000 women had experienced rape in the 12 months prior to the survey, based on the traditional FBI definition; using an expanded reform definition, the rate rose to 62 women per 1,000. Even using the more restrictive parameters, these figures mean that one out of every 55 adult women experienced a rape as defined by the FBI during that one-year period. Using reform definitions now adopted by many states, one in 24 women had experienced a rape in the prior 12 months.

High-Risk Populations. Groups in which the incidence of rape is particularly high include children under the age of 12, adolescent and young adult women up to the age of 25, women on college campuses, minority women, elderly women and the handicapped. Children are most at risk from assaults by family members and other caretakers, and least at risk from strangers (see section on childhood molestation). Similarly, adolescents and young adult women are most at risk for acquaintance and date rape and least at risk from someone unknown to them (see dating violence). Both young adult and older women are more vulnerable to sexual assaults by marital or ex-marital partners than to rape from acquaintances or strangers combined (see discussion of marital rape).

Impacts on Psychological and Social Well-Being

Initial Effects. Initial reactions to sexual assault include shock, numbness, withdrawal and denial. Victims of stranger attacks often are afraid their assailant will return and further harm them, and they may fear retaliation if they contact the police. Victims of attacks by acquaintances or intimates are often stunned that someone known to them or someone they trusted could attack them in this manner. In initial presentations to police or medical staff, victims may appear unnaturally calm and detached (although some physical signs such as shaking or lowered skin temperature are usually present), or they may be crying or angry and emotive.

Typically, there is a lessening of these initial symptoms after the first two weeks and the victim may enter a denial phase, in which there is an outward appearance of adjustment. Those surrounding the victim may comment on how well she has recovered from the trauma and assume that the worst is over. However, studies suggest a period, occurring from two weeks to several months post-assault, in which symptomatology returns and may intensify. It is at this time that the victim may begin a pattern of help-seeking for these symptoms, without informing those she contacts of the rape experience that underlies them.

Long-Term Effects. Research has documented that the "aftereffects" of rape are persistent and long-lasting. Victims often react with chronic anxiety and continued feelings of vulnerability, loss of control and self-blame long after the assault. Common long-term reactions include specific anxiety, nightmares, catastrophic fantasies, feelings of alienation and isolation, sexual dysfunctions and physical distress.

In cross-sectional research, women who have been raped tend to score high on almost every kind of measure of psychological distress, post-assault. In one study, rape victims who were as much as 16 years post-assault were found to have consistently higher levels of fear and anxiety than women without rape experiences. Other long-term effects include mistrust of others, resulting in disruption of personal relationships or styles of relating, the development of phobias, manifestations of depression and hostility, and somatic symptoms. Manifestations of depression may include general apathy or suicidal ideation. Suicidal thoughts are reported in between 33 percent and 50 percent of rape victims in cross-sectional studies. In a community sample of women not seeking treatment, between 17 percent and 19 percent of rape victims made suicide attempts.

High-Risk Groups for Post-Rape Distress. Some studies have found that women who were in situations in which they judged themselves to be safe when they were raped (e.g., at home, with a trusted acquaintance or partner) experience more intense fear and depression after the assault than other victims. Women with prior victimization histories also evidence especially severe aftereffects, particularly depression, as the assault triggers memories of a past assault or childhood molestation. Other factors, such as the level of physical threat, injury and medical complications increase the vulnerability to post-rape symptoms. Although it is often assumed that women who are the victims of stranger rapes are more severely traumatized than those victimized by persons they know, research has not supported this assumption. In comparing victims on measures of depression and anxiety, women assaulted by family members or dates experience as severe levels of distress as women assaulted by acquaintances or strangers.

Posttraumatic Stress Disorder. This complex of effects in the aftermath of rape often meet the criteria for the diagnosis of posttraumatic stress disorder (PTSD). In fact, rape victims are believed to constitute the largest category of PTSD sufferers. Hallmarks of PTSD include psychic numbing, intrusive reexperiencing of the trauma months or even years after the event, avoidance of stimuli associated with the trauma, and intense psychological distress.

Impacts on Physical Health and Well-Being

Initial Effects. Intrusive thoughts about danger, fears about future victimization, and the physiologic arousal associated with these cognitions not only disrupt social and psychological functioning, but often lead to physical symptoms as well. Immediate medical concerns after rape include injury, infection and documentation. Most hospitals have protocols for intervention with rape victims who present themselves to emergency rooms for medical care and testing. In the first weeks immediately following a rape, physical effects of trauma may include soreness, bruising, rectal bleeding and other injuries. Gastrointestinal irritability, fatigue and chronic fatigue, tension headaches, intense startle reactions, and disturbed sleeping and eating patterns also often are noted.

Long-Term Effects. Specific and ongoing health concerns after rape include gynecological trauma such as vaginal tearing or injuries to the vulva, the risk of pregnancy, and the potential for contracting infections or sexually transmitted diseases. Currently, the risk of HIV infection and therefore of AIDS is of increasing concern to rape victims and those who treat them, and contributes to the sense of fear and of irreparable damage with which survivors must deal. Victims may also seek to escape the pain of rape's aftereffects through alcohol and drugs, further disrupting physical and psychological well-being.

Victims' Use of Health Care Services

Rape victims appear to be frequent users of medical services in the months and years post-assault. Survivors perceive themselves as less healthy and report visiting physicians more often than nonvictims, regardless of the length of time since the rape incident. They are more likely to report symptoms in every part of the body (except dermatology and eyes) than nonvictims. They also report more injurious health habits than nonvictims, including smoking, drinking and overeating. In one study, visits to physicians increased 18 percent in the year of the assault, 56 percent in the following year and 31 percent the year after, compared to previctimization levels. Nearly all victims made visits to primary care physicians in each of the two years after the assault.

Special Considerations for Health Care Providers. Although most emergency rooms have established protocols for rape victims who are seen soon after the incident and acknowledge they have been raped, only a small minority of victims seek this type of assistance. Other victims present to private physicians or emergency rooms with complaints based on the symptoms, but do not disclose that an assault has occurred. Still others do not present until months after the incident, but then contact the medical community repeatedly over time in an attempt to deal with long-term effects and complications. Early identification of rape trauma by medical staff can help demystify nonspecific medical complaints and legitimate patient's distress, as well as enabling the physician to make appropriate referrals to help sources to assist with rape recovery. Some lessening of the emotional and psychological distress may, in turn, result in a lessening of symptoms and thus in the need for medical contacts.

Specific protocols that take into account the victim's relationship to the assailant will also contribute to a patient's well-being and the effectiveness of the treatment provided. As noted earlier, women are more likely to be sexually assaulted by their intimates than by strangers. Procedures developed for the victims of stranger rape work poorly in these cases. Victims of intimate assault are less likely to formally report the assault, either immediately or as a part of a medical history, and thus are unlikely to be assisted under established protocols. Even given rape disclosure, established procedures may not provide medical staff with guidance on what to do if the assailant, e.g., the partner, is present in the emergency room or doctor's office. Yet the long-term effects of partner rape are often as severe, and chances of injury greater, than with stranger rapes. Medical protocols should take this into account through the development of procedures for cases of intimate violence. The physical and sexual assault of women by intimates is discussed further in the following section.

PARTNER VIOLENCE

Although the danger of victimization by strangers historically has received the most attention, nationally representative studies consistently indicate that women are most at risk from their intimates, particularly from male partners. In a 1985 survey of intact couples, self-reports indicated that nearly one out of every eight husbands had carried out one or more acts of physical aggression against their female partner during the survey year. Although the stereotype of "domestic violence" tends to be that of relatively minor assaults and squabbles, over one-third of these assaults involved severe aggression such as punching, kicking, choking, beating up, or using a knife or a gun. These findings mean that, in an average 12-month period in the United States, approximately two million women are severely assaulted by male partners. Victims of violence by intimates are much more likely to be reassaulted within six months than those attacked by nonintimates. Women who are separated or divorced from their partners are at the highest risk of assault.

As with other types of intimate violence, figures based on national surveys are marked underestimates. Such surveys typically do not include the very poor, those who do not speak English fluently, those whose lives are especially chaotic, and all individuals who are institutionalized, hospitalized, homeless or incarcerated at the time the survey is conducted. Further, estimates are based on only those respondents who are willing to report, even anonymously, acts of violence they have perpetrated or experienced to an unknown interviewer. Researchers on family violence agree that the true incidence of partner violence is probably double the above estimates, or four million severely assaulted women per year. Studies on prevalence suggest that from one-fifth to one-third of all women will be physically assaulted by a partner or ex-partner during their lifetime.

Risk of Partner Violence for Women and Men

Although some surveys suggest nearly equal participation rates for women and men (i. e., that about as many woman as men have perpetrated at least one act of aggression: threw something, pushed, shoved, slapped, hit, etc.), some clarifications should be noted. First, in this research, no questions are asked about the context within which these actions occur and thus there is no measure of acts that are undertaken in self-defense. Second, the same surveys find that the frequency and types of aggression perpetrated by women and men in partner relationships differ:

a. Men perpetrate more aggressive actions against their female partners than women do against their male partners;

b. Men perpetrate more severe actions — such as punching, kicking, choking, beating up, or using a knife or gun; and

c. Men are more likely to perpetrate multiple aggressive actions against a female partner during a single incident than are women against male partners.

Even when compared with relationships in which women have perpetrated at least one aggressive act, the offending rate for men for severe violence is 42 percent higher.

Severity of Outcomes for Women. In combination with men's greater average physical strength, these factors lead to quite different physical outcomes for women and men. Women are much more likely to be injured by their male partners than men are by their female partners. In analyzing injury reports from the National Crime Survey in 1980, over 80 percent of all assaults against spouses and ex-spouses resulted in injuries, compared to 54 percent of the victims of stranger violence; victims of marital violence also had the highest rates of internal injuries and unconsciousness.

Homicide figures for the United States also demonstrate the differential risk for women and the severity of physical outcomes of partner assault. From 1976 through 1987, the deaths of approximately 38,648 people over the age of 15 resulted from one partner killing another (including homicides by married, common-law, ex-married or dating partners). Of these deaths, 61 percent of the victims were women killed by male partners and 39 percent were men killed by female partners. For white couples, the differences were more marked: 70 percent of partner homicide victims were women and 30 percent were men. Rates for all female perpetrated partner homicides have dropped dramatically since the mid-1970s: from 1976 to 1985, there was over a 25 percent decrease in the overall numbers of women killing male partners. This drop was linked with the presence in a state of domestic violence legislation and other services for abused women, such as shelters and crisis lines. This decrease has not been matched by a similar decline in men killing female partners, however. Over one-half of woman murdered in the United States are killed by a current or former male partner.

Dynamics of Violence Against Wives

Types of partner abuse reported by women in epidemiologic surveys range from being slapped, punched, kicked or thrown bodily to being scalded, choked, smothered or bitten. In relationships with ongoing severe abuse, typical assaultive episodes often involve a combination of assaultive acts, verbal abuse, sexual assault and threats. The repetition of aggression in families is facilitated by the fact that victims are readily available, the amount of time at risk is high, assaults can be carried out in private, and wife-assault is a relatively low-risk behavior for the aggressor, in terms of identification and sanctions.

Until the mid-1970s, assaults against wives were considered misdemeanors in most states — even when the same action would have been considered a felony if perpetrated against a stranger or an acquaintance instead of a wife — and police were not empowered to arrest on a misdemeanor charge. Orders of protection usually were not available on an emergency basis and typically carried no provisions for enforcement or penalties for violation. Moreover, women who eventually killed their mates in protection of themselves or a child found the plea of self-defense unavailable for their case. Only since the late 1970s have domestic violence laws and the provision of shelters and other services begun to more seriously sanction wife assault and offer some protection to abused women.

Characteristics of Persons Involved in Marital Violence

Victims. Early research on abused women focused primarily on women who had sought special services. Accordingly, knowledge of victim characteristics was initially limited to women whose resources directed them to public assistance. Nationally randomized samples now document the diverse socioeconomic backgrounds of victims; although younger women and woman living in poverty are more at risk for both nonmarital and marital violence. However, empirical studies have not found characteristics that differentiate women who are victimized from women who are not, other than their socioeconomic status and the fact that they are abused.

In a review of 52 studies with comparison groups, only one of 42 potential risk markers for women — witnessing parental violence as a child or adolescent — was consistently associated with becoming a victim of marital violence. Studies also suggest that being sexually abused as a child leaves women more prone to revictimization in later life. However, empirically, neither personality factors nor behavioral characteristics distinguished women abused by male partners from nonabused women. Although studies from special populations stress symptomatology, the symptoms that battered women exhibit appear most likely to be sequelae of the violence, rather than its antecedents.

Abusers. Some commonalities have been found among male abusers, however. Men who assault female partners are more likely to have witnessed or experienced violence in childhood, to abuse alcohol, to be sexually assaultive to their wives, and to be at risk for violence against their own or their partners' children than are men in comparison groups of nonabusive males. They are also more likely to be involved in violence toward strangers than men who are not assaultive in the family.

Impacts on Psychological and Social Well-Being

Initial Effects. As would be expected, women victims of a partner's violence have many of the same reactions as other victims. During assaults, the primary focus is on self-protection and survival. Reactions of shock, denial, withdrawal, confusion, psychological numbing and fear are common. During, and even after, an assault, a victim may offer little or no resistance in an attempt to minimize the threat of injury or renewed aggression.

Long-Term Effects. Similar to rape victims, long-term reactions in women abused by male partners include fear, anxiety, fatigue, sleeping and eating disturbances, intense startle reactions and physical complaints. As with other types of trauma, abused women may become dependent and suggestible and find it difficult to make decisions alone and, during the period that follows, minimize the danger and personal loss. Effects of trauma are exacerbated by the fact that the aggressor is someone they may love, someone they are supposed to be able to trust, and someone on whom they may depend. Unlike the victims of strangers, victims of marital violence in fact have a legal, financial and role relationship with their assailants, confounding their decisions on what to do about the violence as well as the psychological sequelae. In such cases, perceptions of vulnerability, loss and betrayal or hopelessness may be especially severe. There is also a high prevalence of depression, and suicide attempts are common. Violence at home typically leaves no place in which defenses can be let down.

Impacts on Physical Health and Well-Being

Injuries sustained by abused women range from bruises, cuts, black eyes, concussions, broken bones and miscarriages to permanent injuries such as damage to joints, partial loss of hearing or vision, and scars from burns, bites or knife wounds. The force with which an act is carried out, the number of repetitions of the act and the clustering of different acts together play a major role in determining the amount of injury sustained.

Injuries from domestic violence typically involve contusions or minor lacerations to the head, face, neck, breast or abdomen. These are often distinguishable from accidental injuries, which are more likely to involve the periphery of the body. In a hospital-based study, victims of domestic violence were 13 times more likely to sustain injury in breast, chest or abdomen than accident victims. They are also more likely to have multiple injuries than accident victims, as well as medical evidence of old injuries (e.g., old and new fractures, bruises in various stages of healing). When this pattern of injuries is seen in a woman, particularly in combination with evidence of old injury and with vague complaints of aches and pains, physical abuse should be suspected, regardless of the explanation given for the current condition.

Primary care complaints include chronic headaches, abdominal pains, muscle aches, recurrent vaginal infections, sleep and eating disorders and depression. Abused women may also begin to abuse alcohol or prescription drugs; although in studies of general populations, alcohol abuse does not distinguish battered women from nonvictimized women. In addition, recent research suggests an association with delayed physical effects, particularly arthritis, hypertension and heart disease.

Victims' Use of Health Care Services

In studies of emergency room visits, 22 percent to 35 percent women presenting with any complaint were there because of symptoms relating to abuse. A project funded by the National Institute of Mental Health estimated that 21 percent of all women using emergency surgical services were there for sequelae of domestic violence, that one-half of all injuries presented by women to emergency surgical services occurred in the context of partner abuse, and that over one-half of all rapes to women over the age of 30 had been perpetrated by an intimate partner. Rather than stating abuse as the problem, however, abused women are more likely to present with depression, anxiety, family/marital/sexual problems, and vague medical complaints. Rates are even higher in special care populations. For example, it has been estimated that 64 percent of hospitalized female psychiatric patients are the victims of physical abuse as adults.

Due to the ongoing and injurious nature of domestic violence toward woman, abused women may visit physicians repeatedly, with increasingly severe physical trauma. In documenting the repeated nature of abused women's visits to health providers, Stark and Flitcraft found that nearly one battered woman in five had presented at least 11 times with trauma; another 23 percent had brought 6 to 10 abusive injuries to the attention of clinicians. Unfortunately, in most cases, the victimization history underlying these injuries was never identified.

Special Considerations for Health Care Providers

Battering During Pregnancy. Victims of a partner's violence during pregnancy face the risk of especially severe outcomes. There is some controversy over whether the incidence of marital violence increases during an abused wife's pregnancy; however, it does not cease. Based on a representative sample, the 1985 National Family Violence Survey found that 154 out of every 1,000 pregnant women were assaulted by their mates during the first four months of pregnancy and 170 per 1,000 women were assaulted the fifth through the ninth month. Medical sources suggest that approximately 37 percent of obstetric patients, across class, race and educational lines, are physically abused while pregnant.

Pregnancy is a particularly high-risk time for an abused woman. Advanced stages of pregnancy leave her less able to maneuver to avoid blows or escape an attack, and more at risk from secondary injuries to herself as well as to the fetus. Further, clinical reports suggest that assaults during pregnancy are frequently related to jealousy or anxiety about the upcoming birth, and that physically assaultive actions such as blows or kicks are often directed toward the abdomen. Such assaults can result in placental separation, antepartum hemorrhage, fetal fractures, rupture of the uterus, liver or spleen, and preterm labor. One study found that abused women were three times as likely to sustain injury while pregnant as nonabused women.

Physical abuse may lead to fractures, bruising or hemorrhage. Although few specific studies of the impact on birth outcomes have been done, physical violence during pregnancy has been linked to low birth weight in newborns. Physical or sexual assault may stimulate early labor by irritation of the uterus, premature rupture of the membranes or injury to the reproductive organs. Indirect causes of poor birth outcomes for a woman who is victimized at home include social isolation, diminished personal and social support, inadequate access to prenatal care and other services, inadequate maternal nutrition and a concentration of injury on the reproductive organ systems.

Because of the high incidence of women who are assaulted during pregnancy, those providing pre- and postnatal care have an excellent opportunity to identify this abuse and to reduce the potential negative outcomes. Abused women should be given intensified prenatal care, appropriate for high-risk pregnancies. Guidelines for physicians working in the area also urge that every effort be made to identify women who are victims of abuse, and to provide them with information about their rights under the law and available community, social and legal resources.

Marital Violence and Child Abuse Unfortunately, risk to the children of abused women does not stop at birth. Studies of the co-occurrence of wife and child abuse document that men who abuse their wives are more likely to be abusive toward children than are nonabusive men, and that extreme violence toward female partners is highly associated with concurrent child abuse. There is also a strong association between severe marital violence and the frequency of child abuse. In a nationally representative survey, more than half the males who were severely violent toward female partners abused their children three or more times during the year prior to the survey.

Conversely, in a hospital-based comparison study based on reviews of all child abuse reports filed at a Boston emergency room for a six-month period, records of 59 percent of the mothers were diagnostic or highly suggestive of a victimization history. This was significantly higher than the prevalence of wife abuse among mothers of children in a non-abused comparison group — 16 percent of mothers in the comparison group had been abused. Surprisingly, the rate of violence against single mothers of child abuse victims was four times the rate of mothers who were married, suggesting the need to consider the possibility of trauma histories in all mothers regardless of their marital status at the time they are seen.

Studies also find that mothers who are the victims of frequent abuse are more likely to victimize their children than nonabused mothers, and that mothers who experience severe violence are more likely to use severe measures in resolving conflicts with their children. Some in-depth research suggests that mothers are up to eight times more likely to physically abuse a child when they are in a violent relationship than when that same mother is with a nonviolent partner. Some child and adolescent abuse is also the unintended result of parental violence. Adolescents who attempt to intervene, and young children who may be in their mother's arms or otherwise in close proximity to her when an attack occurs, are at particularly high risk.

MARITAL RAPE

Although a neglected topic in both the areas of family violence and medicine, empirical research has shown consistently that marital rape is an integral part of the patterns of marital violence. In a random sample in San Francisco, 14 percent of ever-married women reported being raped by a husband or ex-husband, more than twice as many as were assaulted by strangers. Similarly, in a representative sample in Boston, 10 percent of women cohabiting with a spouse or intimate male reported at least one sexual assault occurring in that relationship.

Marital rape has been reported in relationships in which no other forms of physical abuse occur. However, it seems to be most frequent as a form of aggression in relationships in which other violent behaviors are ongoing. Sexual assault is reported by 33 percent to 46 percent of women victims who are being physically assaulted by their partners. Research on severely violent relationships indicates that the most violent assaults often include sexual as well as physical attacks, and that battered women who are sexually assaulted by their partners typically experience more severe nonsexual attacks than other abused women. In severely abusive relationships, violent, forcible sexual assault may occur as often as several times a month.

Sexual abuse is an extremely serious form of marital violence. It is possible to inflict an intense level of physical pain over a long period of time, and to cause a wide range of injuries, from superficial bruises and tearing to serious internal injuries and scarring. The psychological impact of sexual assault by an intimate can also be extreme. Victims of marital rape suffer many of the same reactions as other rape victims and are likely to exhibit particularly severe sequelae, both emotionally and physically (including very severe depression and suicidality). Yet, except for child sexual molestation, this type of violence is least likely to be reported by victims, either to medical care providers or to police, due to the shame of the victims, fear that they will not be believed or belief that forcible sexual relations are the "right" of a husband or male partner. An awareness of the potential for forcible sexual assault in marriage, particularly in cases in which other types of physical abuse have been identified, will enable the clinician to sensitively assess for marital rape as a tool for understanding the etiology of observed symptoms.

COHABITING AND DATING VIOLENCE

Although the prevalence of marital violence has led some researchers to call the marriage license "a hitting license" (at least 30 percent of all couples have had at least one act of physical aggression between them), recent investigations have found at least as high a prevalence of physical assault among dating and cohabiting couples. Findings on "dating violence" are quite new in the social science literature and interpretations of those findings can be problematic. However, studies are limited almost exclusively to students in high school and college. Very little is known about individuals between the ages of 14 and 22 who are not attending school or about those who are past college age and dating or living with their partners despite the fact that many who seek medical services at hospital and community health centers come from these groups.

Dynamics of Dating Violence

Data from the National Family Violence Survey in 1975 documented higher rates of partner aggression among cohabiting couples than married individuals. Similarly, results from the 1985 Resurvey, as well as responses from students at a midwestern university, indicated a higher level of assaults between cohabitants than in the college sample of dating couples or the national sample of married couples, and higher rates among dating couples than married. As with other types of intimate violence, the risk of injury, and of lethal injury, is quite different for women and men. In one study of college students, women were four times as likely to sustain moderate to severe injuries as a result of dating violence than were males.

Self-reported motivations for perpetrating dating violence also differ. Whereas most women give self-defense or retaliation as their motivation, male respondents were most likely to report that the purpose of their violence was to "intimidate," "frighten" or "force the other person to do something." Violence as a response to sexual denial was also frequently reported by males. If violence occurs once in a dating relationship, it is very likely to occur again, with a mean number of 9.6 incidents. Thus it is not surprising that these assaults may result in injury over time.

Sexual Assault In Dating Relationships

Rape victimization for females is highest in the 16-19 year age group and next highest in the 20-24 year age group, with overall rates about four times as high as the mean for all women. In some research on college campuses, 20 percent to 25 percent of college women reported forcible sexual attempts by a date, and 26 percent of college men reported making forcible attempts or forcible rapes. In one study, 35 percent of male university students reported a willingness to commit rape under certain circumstances (i. e., if assured the rape would not be reported) and adhered to strongly rape-supportive beliefs and attitudes. A carefully administered survey of over 6,000 college students found that 42 percent of women students reported some type of sexual assault, including forcible sexual contact, attempted rape and completed rape. Rapes and attempted rapes involved greater levels of violence than did nonsexual assaults in dating relationships. Rates of rape victimization did not vary significantly based on whether the school was large or small, or located in an urban, metropolitan or rural area. Current estimates suggest that one in 3.6 college women has been a victim of rape or attempted rape during their lifetime. In investigating the incidence of forcible rapes and attempted rapes of adolescent girls, a national survey (based on reports of the perpetrators) estimated a minimum of 540,000 assaults of female teenagers per year.

Increasing Severity of Nonmarital Violence for Women

The reported levels of both nonsexual and sexual physical assaults against girls or women by nonmarital intimate partners have increased during the past 15 years. Although some of this may be due to a greater sensitivity to dating and cohabiting violence as an issue, levels of severe intimate violence against women do appear to be increasing. For example, although the rate of homicide victimization for male partners in dating or living-together relationships has varied unsystematically, the rate of females killed by dating or cohabiting partners increased sharply from 1976 through 1987. This may be due, in part, to a lack of interventions targeted for dating and cohabiting partners. Shelters and most domestic violence legislation tend to address problems of safety and access for those who are married or cohabiting. Few, if any, services – except on some high school or college campuses – are structured for individuals assaulted by a dating partner. Thus it is possible that the relationship types with the highest risk for violence, sexual assaults and lethal violence are the ones least served by current societal interventions.

Considerations for Health Care Providers

Violence in dating relationships traditionally has been considered relatively nonserious, with few services or protocols designed to address it. However, recent evidence on the prevalence, morbidity and increasing number of male-perpetrated homicides in these relationships requires serious attempts to identify violence between nonmarried intimates and effectively intervene. Screening techniques to assess for current or past victimization should be utilized for all categories of female patients, regardless of demographic or relational circumstances.

SEXUAL MOLESTATION IN CHILDHOOD

Finally, a history of childhood sexual molestation is highly associated with enduring physical and psychological sequelae, so that a lack of knowledge regarding this history may confuse the medical and psychological picture as viewed by a physician. Child sexual molestation is typically not assessed as part of an adult intake evaluation. However, left unaddressed, the long-term effects in victims can be pronounced. Further, clinical studies indicate an exceedingly high prevalence of child sexual abuse histories in psychiatric patients. Given its salience for treatment providers working with adult (as well as child) populations, the effects of child sexual molestation will be briefly discussed.

Cases of child sexual assault first became recognized in large numbers in the 1970s. Prior to this, sexual molestation of children was thought to be relatively rare and to occur only in the most pathological of families. General practitioners expected to see one or two cases at most in their lifetime. In recent years, however, the American Humane Association has documented an increasing number of reported cases of child sexual victimization and several studies have been conducted. Again, some of the increase in reporting is related to an increase in public sensitivity. In the past, children were primarily at risk from fathers, other male relatives and close family acquaintances. While these risks remain, children today may also be at risk from greater use of outside child care by single and divorced working mothers; the use of foster care as the treatment of choice for abuse within families without adequate screening procedures for foster care settings; and national trends toward living together and shorter marital relationships which may put children at risk from stepfathers and mothers' boyfriends.

Long-Term Effects

Impacts on Psychological and Social Well-Being. Long-term effects of the experience of child sexual molestation include impacts on emotions, self-perception, social functioning and physical well-being. Depression is the symptom most commonly reported among women molested as children. Adult survivors are more likely to report depression and to have been hospitalized for depression than other types of victims or nonvictims. A high incidence of self-destructive behavior, both suicide ideation and deliberate self-harm (e. g., cutting, burning or otherwise inflicting self-injury) has also been found in adult survivors of child sexual assault; distinguishing them even within clinical populations. This includes an exceptionally high prevalence of suicide attempts reported among adult survivors in community and college (up to 18 percent), as well as clinical (up to 51 percent) samples. Symptoms of anxiety or tension, including chronic and severe sleep disorders, anxiety attacks, chronic fearfulness and hyper-vigilence, also frequently are noted in survivors, along with disturbances in adult sexual pleasure and comfort.

Survivors of child sexual molestation also report a general sense of alienation persisting into adulthood, as well as difficulty trusting others, relating to women and to men and parenting. Even in general populations, a high percent of the victims of child sexual molestation continue to feel isolated and stigmatized as adults. Although by no means inevitable, approximately one-fifth of child sexual abuse victims evidence serious long-term psychological effects. These may include dissociative responses triggered by specific stimuli or anxiety-producing stressors, as well as other PTSD indicators such as numbing of affect, chronic states of inappropriate arousal, nightmares and flashbacks. Victims who have experienced abuse by fathers or stepfathers, whose assaults involved genital contact or whose molestation involved force, appear to be at especially high risk for severe long-term sequelae.

Perhaps most troubling is the apparent vulnerability of women who have been sexually abused as children to be revictimized later in life by both strangers and intimates. A persistent vulnerability to revictimization is one of the most consistent findings in both clinical and empirical literature. In one random sample study, 33 percent to 68 percent of the sexual molestation victims later experienced a rape (depending on the seriousness of the childhood abuse they suffered) compared with 17 percent of women who were not child victims. In a survey of college students, women who had been sexually abused before the age of 13 were the most at risk to later become victims of nonconsensual sexual experiences. Victims of child sexual abuse also are more likely to be physically abused by husbands or other adult partners when they reach adulthood. Other evidence shows that many women who engage in prostitution were victims of abuse as children, and violence perpetrated against current prostitutes is not uncommon.

Impacts on Physical Health and Well-Being. Many of the long-term physical effects discussed in the section on rape are also seen in adult survivors of childhood sexual abuse. Somatic disorders include abdominal pain, headaches and eating disorders (e. g., anorexia or bulimia). Adult victims may also evidence the effects of venereal disease. In a study of children, sexual victimization resulted in the transmission of venereal disease in 13 percent of 409 victims. Documented sequelae of child sexual abuse include herpes, chlamydia, gonorrhea, syphilis and trichomoniasis. Female victims of child sexual assault also are at higher risk for substance abuse and the development of alcoholism than women without this childhood history. Experiences with child or adolescent sexual molestation may also engender a pattern of early drug use, with cumulative long-term effects.

Special Considerations for Health Care Providers

In patients presenting themselves for medical care, a history of child sexual molestation is almost always masked by other presenting problems. Further, medical and psychological symptomatology may be compounded by revictimization experiences, as well as by other life experiences resulting from emotional or behavioral sequelae. Indications that a history of child sexual abuse should be explored include: (1) symptoms of posttraumatic stress disorder, without an apparent history of current or past rape, dating violence, partner abuse or other trauma; (2) evidence of ongoing severe depression, especially if accompanied by self-harm, including physical disfiguring of the body, eating disorders and/or suicide attempts; (3) evidence of sexual dysfunction or unusual anxiety involving sexual activities or exposure of the body (possibly including medical, and especially gynecological, examinations); (4) early onset of alcohol or drug abuse; (5) childhood history of running away, or placement in foster care or institutions; and (6) a history of repeated physical or sexual victimizeton.

PSYCHOPATHOLOGY VERSUS THE EFFECTS OF TRAUMA

Clinical studies have identified a high incidence of depression and elevated levels of alcohol and other substance abuse in women victims of violence — particularly those seen in emergency and inpatient settings, sometimes leading to DSM-IIIR Axis I diagnoses. Diagnoses of personality or developmental disorders (Axis II) are also frequently assigned to women with histories of rape, child sexual molestation or battering. A personality disorder is a diagnosis of social dysfunction and does not take into account the influence of environmental factors extrinsic to the organization of the personality. It may also be a problematic diagnosis for cases in which a trauma history is present, particularly if that history is not known to the clinician.

For example, in one study of adult women with sexual molestation histories, two-thirds met the diagnostic criteria for posttraumatic stress disorder. However, none had received that diagnosis and, in most cases, dealing with the impact of the childhood trauma was not even considered in treatment. Yet both substance abuse and chronic depression, rather than symptoms of an Axis I disorder, may be the long-term effects of a history of victimization and are frequently found as sequelae to child sexual assault. Similarly, battered women's reactions to the violence they have experienced may approximate behavioral descriptors for borderline or other (Axis II) personality disorders, although the same individual might not have met the criteria for the disorder before the onset of recurring attack. An adapted MMPI (Minnesota Multiphasic Personality Inventory) is now available for the assessment of battered women to accommodate the presence of real danger in their lives.

Clinicians in medical settings suggest that, in many cases, a diagnosis of Posttraumatic Stress Disorder (PTSD) is often the most accurate for victims of intimate violence. The "most common traumata" suggested in the DSM-IIIR for PTSD is "a serious threat to one's life or physical integrity, or a serious threat or harm to one's children . . ."; the discussion suggests that the disorder is "apparently more severe and longer lasting when the stressor is of human design." Further, the presence of ongoing physical or sexual abuse is listed under the "Extreme Stressor" category — category number five on the Axis IV classifications of severity. (The only category more severe is reserved for "catastrophic" events and includes captivity as a hostage and concentration camp experiences.) However, for behaviors to be seen as posttraumatic stress reactions, the trauma must be known — something that is not possible if a detailed victimization history is not obtained and effects are interpreted in isolation.

Given the disruption of developmental tasks and stages, Axis II diagnoses are undoubtedly appropriate for some family violence victims. In other cases, extreme stressors (e. g., violent attack) may contribute to the emergence of a psychiatric disorder. Inclusionary criteria for PTSD, structured for situations in which the primary stressor is no longer present, do not always fit current reactions of victims who are faced with ongoing threat or danger. New designations, now being field tested, may provide expanded classifications to better account for both the reactions of individuals who have been victimized in the past, as well as those who must respond to periodic assault and threat in their present environments.

IMPLICATIONS FOR POLICY AND PRACTICE

Physicians and other health care providers rarely probe for the underlying causes of the injuries they treat. However, a treatment plan based primarily on the treatment of symptoms is ineffective for a victim of violence if assaults are ongoing and thus sequelae continually recur. Physicians and medical staff become frustrated with trauma patients who return frequently with nonspecific and chronic complaints, symptoms that the best medical care seems unable to alleviate. Treating only the symptoms initiates a cycle of patient contacts with medical and mental health service providers, with the attendant risks of increasingly severe and debilitating sequelae for the patient, as well as the exhaustion of resources within the system providing care. A more efficient response over time is for medical professionals to routinely screen for victimization, including intimate physical and sexual assault, in their initial as well as ongoing assessments, and to develop treatment plans that address the cause of the trauma as well as its manifestations. Often, knowledge of a history of victimization provides a starting point from which to disentangle a confusion of presenting complaints and symptoms.

Guidelines for Medical Settings

Structured resources within a medical setting will greatly facilitate effective interventions. Basic components for targeted responses to violence against women include:

Training — to develop sensitivity to these issues, including an awareness of risk factors, indicators, estimated prevalence in the general and patient population, sequelae and considerations for health care providers. Training should include becoming familiar with assessment procedures and interviewing techniques as recommended in the setting, as well as with risk assessment, safety planning and procedures for linking to resources. Further, training on interpersonal violence should be incorporated into core curriculums for undergraduate, graduate and continuing education for those in the health professions.

Protocols — to assess for current or past victimization as a routine part of obtaining a medical/psychiatric history. Procedures established for cases in which victimization is identified should be adequate to give specific guidance, based on the type of abuse and the individuals at risk (e.g., protocols for the victims of stranger versus marital or date rape; for a woman victim where a child is also at risk). Procedures should also include a system of tracking in which the numbers and types of cases seen can be tabulated and patients who repeatedly evidence abuse can be identified.

Response Staff — within the medical setting if possible to whom victims can be referred. Tasks of response staff would include immediate safety planning, making victims aware of their legal rights, area resources for safety and intervention and services available within the hospital and their community. Staff would follow up with patients and act as a link with both in-house and community resources. Other tasks of the response staff would include coordination of the tracking system, identification of high-risk (and repeat) cases, and coordination of triage efforts for intensive intervention with special risk cases.

Referral Sources — within the community or area for women victims of violence. Medical settings should make themselves aware of and develop linkages with a variety of area resources including battered women's shelters and crisis services, rape crisis centers and services, services for adult survivors of child sexual abuse, services for homeless women, legal services for women victims, treatment programs for men who abuse female partners, and services for abusive parents. A priority on the development of a wide-ranging referral network, and the maintenance of positive and reciprocal relations with the entities in this network will be of great benefit to patients and their families as well as to medical personnel who would no longer be required to carry the full burden of intervention.

These community resources could work collaboratively with hospitals or practices to see victims in the medical setting or to train staff to become more knowledgeable in these areas. At the same time, the health care community — hospitals and residency training programs as well as individual physicians — might provide in-kind services such as evaluations, screenings and testing. Such services might best be provided on site wherever the community resources are located.

Health Care Goals for Women Victims of Violence

Treatment goals for women victims of violence include the attainment of physical health, mental health and safety from further harm. At the AMA National Leadership Conference, Robert McAfee, M. D., current Vice Chairman of the Board of Trustees, stressed that violence in America has become a "public health crisis of epidemic proportions," and urged doctors to take an active role in finding solutions to the effects of violence on the patients they serve (Doctors Urged to Act In "Crisis" of Violence, American Medical News, March 4, 1991). In a similar vein, Surgeon General Novello has urged that physicians not be deterred in finding a role for themselves in the solution, noting "the human cost alone more than justifies swift action by physicians to reduce these deaths and injuries."

Although the problem of violence against women is pervasive and complex, a place to begin is in incorporating this knowledge into routine questions for assessment, sensitive responses to disclosure and effective referrals to resources.

Routine Screening Leading to Identification of Female Patients Who Are or Who Have Been Victims of Violence. Routine screenings should be carried out at the entry points of contact between women and medical care, e.g., primary care, emergency services, obstetric and gynecologic services, psychiatric services, pediatric care, etc. Protocols to assess for victimization will vary somewhat, depending on the medical context, but should be based on assessment instruments in the scientific literature and address the various types of victimization women experience. Guidelines for obtaining information on a trauma history, identifying coping mechanisms and assessing the potential for further danger are provided by McLeer and Anwar, Patten and colleagues and the American College of Obstetricians and Gynecologists.

Validation of the Experience of Victimization and of Observed Symptomatology as Possible Sequelae. An explanation that many people experience physically aggressive actions from their intimates, that often they are afraid to tell anyone about it, and that such experiences can have painful and even dangerous sequelae should accompany assessments for victimization and characterize professional responses to disclosure. One of the greatest services a physician can provide to a patient is to acknowledge the trauma and validate it as a threat to physical and emotional well-being. In discussing physician's responses to abused women, Anne Flitcraft, M. D., notes that "the very acknowledgement that domestic violence is going on, and that you and she agree it is a serious problem, is a very powerful and therapeutic first step."

Record-Keeping Regarding Victimization History, Observed Traumata Potentially Linked to the Victimization and Referrals Made. Archival studies of medical records note that victimization histories, if noted at all, are typically included with a list of symptoms or behavioral problems, e. g., "Patient presented with bruises and minor lacerations. Complains of chronic back pain, sleeplessness and menstrual irregularity. Reports marital difficulties with some hitting, some evidence of substance abuse." More specific documentation, including (a) indications of a trauma history from the initial screening, (b) what the patient has disclosed about past or current victimization, (c) a description of symptomatology potentially linked to the victimization and (d) referrals made, based on this history provides a basis for later review of treatment plans. Such a record is also useful to assess progress, or to indicate the need for more intensive interventions at a later contact with the patient.

Referral to Within-Setting and/or Community Trauma-Specific Resources. After disclosure of victimization to a physician or other staff, referral should be made as quickly as possible to specially trained staff within the setting or, if none are available (e. g., in a private practice), to outside resources. Whenever possible, these resources should be "trauma-specific" — e. g., rape victims would be referred to those with expertise in rape crisis and/or marital or date rape, abused woman would be referred to resources with expertise in domestic violence, and so forth. Consonant with the goals stated at the beginning of this section, referral and intervention procedures should take into account the safety of the woman victim.

Particularly in cases of domestic violence where victims are still with their abusers, protocols need to address (a) the handling of referrals when the assailant is on the premises, (b) procedures for response if the immediate need of the patient is for protection and (c) the context within which the "problem" of ongoing abuse and threat is to be addressed. In a medical setting, such cases are most typically referred for family (or couples) counseling, but are almost never referred to resources designed to deal with women who are or have been victimized by intimates. Physicians and other medical personnel frequently do not even know what resources are available in their area with expertise on wife abuse, rape and date rape, or shelter. Referring a victim to counseling with her assailant is potentially dangerous. If she has no opportunity to work through some issues apart from him, a victim may resist discussing the issues, or completely deny that a problem exists, in an attempt not to anger her partner and further endanger herself.

RECOMMENDATIONS FOR POLICY

The Council on Scientific Affairs recommends that:

1. The American Medical Association, working with members of the federation and other relevant organizations, undertake a campaign to alert the health care community to the widespread prevalence of violence against women, that the effects of such violence are likely seen on a regular basis, and to sensitize them to the needs of victims of violence;

2. The AMA encourage physicians to routinely incorporate screening leading to identification of female patients who are or have been victims of violence;

3. The AMA encourage physicians to give due validation to the experience of victimization and of observed symptomatology as possible sequelae;

4. The AMA encourage physicians to record a patient's victimization history, observed traumata potentially linked to the victimization, and referrals made;

5. The AMA encourage physicians, after diagnosing a violence related problem, to refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible;

6. The AMA encourage the incorporation of training on interviewing techniques, risk assessment, safety planning and procedures for linking to resources into undergraduate, graduate and continuing medical education programs;

7. The AMA collect and disseminate protocols on identifying and treating victims of violence and develop, in conjunction with other relevant organizations, guidelines for treatment where protocols are absent; and

8. The AMA include appropriate information detailing the important role of substance abuse in the etiology, treatment and prevention of violence against women in its efforts.

(References pertaining to Report B of the Council on Scientific Affairs are available from the Office of Science and Technology.)

K. UPDATE ON THE AMA'S NATIONAL CAMPAIGN AGAINST FAMILY VIOLENCE

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED:

Report FF of the Board of Trustees, Update on the AMA's National Campaign Against Family Violence (Policy 515.980), recommended that ongoing efforts on family violence continue to be an action item at each of the annual meetings of the American Medical Association and that the impact of drugs and alcohol on family violence be studied and included in future updates. Report G of the Board of Trustees (I-91), A Proposed AMA National Campaign Against Family Violence (Policy 515.986), outlined an action plan of activities to address family violence.

COMMUNICATION STRATEGIES

On June 10 and 17, 1992, issues of the Journal of the American Medical Association (JAMA) and specialty journals were devoted to the topics of "Violence in America" and "Domestic Violence," respectively. The release of these issues was preceded by a press conference held in Washington, D. C. As a result of the excellent reception to these journal articles, a compendium from JAMA, American Medical News and the specialty journals of the American Medical Association, titled "Violence," was assembled and distributed. The compendium represents the most current research and up-to-date literature reviews on the topic of violence and family violence.

NATIONAL COALITION OF PHYSICIANS AGAINST VIOLENCE

The National Coalition of Physicians Against Violence currently has a membership of 4,000. New registrations are received daily. All members of the Coalition receive membership cards, a mission statement, a family violence poster, a newsletter and a set of the four diagnostic and treatment guidelines published by the American Medical Association.

The primary purpose of the Coalition is to provide the nidus for the development of violence prevention committees through local medical societies. This is already occurring in 16 states. Lists of Coalition members have already been sent out to state and local medical societies. In addition, the Division of Communications has developed a project book titled "What You Can Do About Family Violence." The book is designed specifically for use by state and county medical societies, and makes suggestions for the development of violence prevention committees.

A National Advisory Council on Family Violence consisting of representatives from the specialty societies has been organized. Forty specialty organizations have designated representatives. The first meeting of the group was held in Chicago in September 1992. A second meeting of the Council was held in Washington, D. C., on April 1-2, 1993. While still in the formative stages, the Advisory Council is examining issues concerning medical education, federal and state legislation, and the needs of professionals working in the various areas of family violence.

An outgrowth of the Advisory Council's activities includes the formation of a group of medical school deans interested in developing curricula on the different forms of abuse for undergraduate clinical education. Once completed, the model curricula will be disseminated to medical schools around the country.

NATIONAL MEDICAL RESOURCE CENTER

The National Medical Resource Center on Family Violence continues to gather protocols and guidelines which address the various forms of abuse. Through the National Resource Center, the AMA's Diagnostic and Treatment Guidelines on child physical abuse, child sexual abuse, domestic violence and elder abuse have been widely distributed.

Reports from the various AMA Councils have also been made available through the National Resource Center. In addition to existing reports on violence against women, adolescents as victims and perpetrators and physicians and family violence, the House of Delegates will consider at its 1993 Annual Meeting a report on substance abuse and family violence. Reports on the impact of family violence on mental health and violence against men are currently under preparation.

IMPACTING THE HEALTH CARE SYSTEM

Beginning in January 1992, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) required hospital emergency departments and ambulatory care facilities to meet standards for all forms of abuse: child abuse, sexual assault, domestic violence and elder abuse. The standards require that policies and procedures be in place to address diagnosis, appropriate treatment and referral, and staff education in order to be accredited by the JCAHO. The American Medical Association, the American Hospital Association and the Education Development Center, Inc., of Newton, Massachusetts, have completed a proposal which, when funded, will allow for the development of model protocols and education and training programs to assist hospital staff in complying with the new JCAHO standards.

NATIONAL INVITATIONAL CONFERENCE ON THE PREVENTION OF FAMILY VIOLENCE

A National Invitational Conference on Family Violence will be held on March 11-13, 1994, in Washington, D. C. The Conference will focus on how medicine and the law can work effectively together to address the problems of family violence. National organizations representing medicine and law, leading attorneys and physicians specializing in issues of family violence, and members of Congress interested in family violence will be invited to attend the Conference. Outcomes for the Conference include the development of programmatic activities to be embraced by national organizations and policy recommendations to be delivered to Congress and state governments. A planning meeting for the Conference will be held March 31, 1993. Cosponsorship by the American Bar Association, the American Dental Association, the American Hospital Association and the American Nurses Association has already been agreed upon.

THE AMA'S CONTINUED INVOLVEMENT ON VIOLENCE ISSUES

Family violence, as compared to other more global types of violence, was selected by the Board of Trustees because of its more direct relevance to practicing physicians. Nevertheless, research has shown that violence occurring in the family is carried over to the community. The possibility that children who are victimized may continue to perpetuate the cycle of violence as adults in their own families, as well as the broader community, is an issue receiving attention by the research community.

International homicide rates for males 15-24 years of age suggest that the United States is the most violent country in the world. Our own experiences seem to substantiate this finding given the recent problems in Los Angeles, the number of articles in our newspapers about drive-by shootings, the rising homicide rates, children coming to school with guns, and the often heard denunciation about the amount of violence portrayed on television.

Since the initiation of the Physicians Campaign Against Family Violence in October 1991, the American Medical Association has received extremely positive feedback from physicians, other professional groups and the general public. The Campaign began as an effort to heighten awareness among physicians regarding the abuses constituting family violence and to educate them in appropriate diagnosis and treatment. This work began with the issuing of the AMA Diagnostic and Treatment Guidelines on child physical abuse, child sexual abuse, domestic violence and elder abuse.

The AMA's involvement in the area of family violence has catalyzed a variety of positive responses from the public, the news media, professional organizations, advocacy groups, members of Congress and other governmental

agencies. The AMA is clearly viewed as a leader in this area and has given the issue of family violence a prominence that few other organizations could provide. Indeed, many complementary programs have been launched by constituent societies in the federation as well as by the Auxiliary and other distinguished organizations. The AMA's efforts have also provided a forum for discussion among all those concerned with this issue.

To extend its leadership role in this area of public health, AMA efforts must include coordination and violence prevention. While diagnosis and treatment is of great importance to physicians, a public health approach that places emphasis on primary prevention of violent behaviors is indicated.

RECOMMENDATIONS

The Board of Trustees recommends that the following policy statements be adopted:

I. Recognition, Safety and Treatment

A. The AMA should provide educational and training opportunities for physicians in diagnosing, treating, and referring cases of abuse constituting family violence;

B. Work with the American Hospital Association to encourage the development of hospital-based programs for the diagnosis and treatment of abuse among all people, especially in geographic areas of high risk for violence;

C. Work with the American Hospital Association to encourage the development of multi-disciplinary hospital-based teams of professionals to assist physicians and other health professionals in the diagnosis and management of family violence cases;

D. Develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education.

II. Coordination of Efforts of Violence Control and Prevention Activities

A. State and county medical societies should convene or join state and local health departments, criminal justice and social service agencies and local school boards to collaborate in the development and support of violence control and prevention activities. These efforts should be coordinated through state and local health departments.

B. Hospitals should meet with agencies within their own communities that provide assistance to victims of family violence and develop protocols for working with one another.

C. Collaborate and coordinate with the Centers for Disease Control and Prevention supported comprehensive school health programs initiative to develop health education curricula for grades kindergarten through 12 on topics including violence avoidance, conflict resolution and enhancement of self-esteem.

III. Primary Prevention

A. State and county societies should support violence prevention committees made up of physicians and members of the AMA Alliance for the purpose of establishing local agendas;

B. Encourage all physicians to routinely screen for the effects of violence and abuse in all patients;

C. Develop a "train-the-trainers" program on primary prevention for physician members of the National Coalition of Physicians Against Family Violence to work within local school districts to implement educational programs on violence prevention and substance abuse.

IV. The AMA should study the problem of domestic violence in doctors' families and make recommendations concerning approaches to recognition and treatment.

Senator COHEN. Thank you very much, Dr. McAfee.
Dr. Brown.

STATEMENT OF ERIC R. BROWN, M.D., FACULTY PHYSICIAN, FAMILY PRACTICE RESIDENCY CENTER, EASTERN MAINE MEDICAL CENTER

Dr. BROWN. I also want to thank you for allowing me the time to bring this forward before you, an issue that is near and dear to all physicians. I have been working on the issue for about 10 years in the State of Maine, and it feels good to be asked about this issue. For the past 5 or 6 years, the usual response to me addressing violence issues was "there he goes again," because it's not an interesting issue, it hasn't been for a long time.

And I applaud the AMA for finally coming about, coming around to this issue because for the longest time there were closed doors in dealing with this issue.

I also want to commend the three people that came before us. One of the issues that comes to bear with this problem is that you don't have a constituency. You don't have a lot of people going into the Senate and raising their hand and saying, "By the way, I'm an alcoholic" or "I'm abused, and I want you to do something about it," because it's a very shaming disease, being in a family with this sort of violence.

I think that it took a lot of guts and a lot of courage for those people to come up here, and I really think they need to be applauded. The case I want to make——

[Applause.]

One of the other cases I want to make before I get started is that there has to be an integrated approach. I know we're talking about how can our health care system respond? And I appreciate that. But without a coordinated approach from all community members it's going to be a bust.

You can't have one group doing one thing, another group doing another thing, you know, DHS doing another thing. That's the problem. We have all these separate entities trying to do it all, and it won't be successful.

The AMA can do its best to influence physicians to learn it and hold a carrot in front of them, but they're not going to learn it unless there are other pressures brought to bear.

I'm going to start with the practice—I'm sorry that I wrote such a tome beforehand, but I felt this was so important that I wanted to say it all, but I'll try to keep it short.

Senator COHEN. Don't read the whole tome.

Dr. BROWN. I won't read the whole tome. I will just hit some highlights. We live in a culture of violence. One of the things that we have is a rule, and it's still there—spare the rod and spoil the child.

That's still supported in some courts. Still some physicians support that. And what we teach our kids in violence and touching and all that sort of stuff is what they're going to learn to do later. The love they learn is the love they give later.

And I think there is one thing we have a hard time understanding, and I hope you'll excuse my language; but if I tell my young

child, my 2- or 3-year-old, "Don't swear, you little shit," guess what he's going to do? He's going to swear.

But for some reason, it's a little hard for our communities to understand that. "Don't hit, you little son of a gun, or I'll smack you for hitting." How come that doesn't compute in the mind of most of our population?

Somehow, spare the rod and spoil the child is still important. You must teach by violence and by power. And kids take with them what you give them.

Senator COHEN. Let me interrupt you here for a moment. I spoke at Girls State last evening, and I mentioned the caning of Michael Fay and took a little poll of who was in favor. Almost three-quarters were in favor of the caning of Michael Fay.

Dr. BROWN. It's absolutely scary. Just as a little aside, you know where the rule of thumb came from? The rule of thumb was a law that a man could beat his wife only with a stick as thick as his thumb.

And I think that people need to realize that violence has been institutionalized toward women in our society. It's there.

So what I brought for you in my document here was the principal problem that starts with child abuse and neglect and progresses to later domestic violence, and I brought some data, and you already mentioned some of this, regarding the Department of Human Services.

What you don't know is that the Department of Human Services is so out straight that they screen out somewhere around 80 percent of the cases, not because they're not deserving of evaluation but because they don't have the staff.

Abuse workers and other people who help in this area are the first to be cut in the system because they don't have the constituency that's going to get up and jump up and down and get help.

I think at least 25 to 35 percent of my patients that I screen—I ask every patient about this sometime during the course of my working with them—about violence in their past, and current violence. They come up positive; if asked in a nonjudgmental way, you find out.

You know, in medicine we have this thing, WNL; that's supposed to mean within normal limits. I'm sure Dr. McAfee and I know that it also means we never look. And sometimes that's what happens. We don't look.

Physicians don't examine very well. I am frequently in the situation in my office where I am the first person to examine externally a little girl's genital area. Guess what?

I find abuse if I look, and I end up being "the heavy" many times because nobody's ever looked before, and the mother and the child are saying, "Why are you doing this?" The problem is because nobody else does it. That's a big issue. There's no good screening.

If a physician in his office had a 60-year-old man visit for a routine physical and didn't ask him about chest pain or other routine screening questions about risk, it would be considered malpractice. That's not the case in abuse.

So it's rampant, and I don't want to get into the specifics of the numbers here but I want to get into why physicians don't ask the questions, and I think it's really important that we look at that.

First of all, physicians are a selected group of people, partly for their intelligence but also for their compulsiveness. The latter is sometimes a result of their own life's issues: some coming from families with major dysfunction. When I ask these questions—I give out handouts usually at lectures to community physicians—a higher percentage of physicians and other health care workers, at least in my experience, have experienced family violence or alcoholism and neglect than a lot of other people.

And somehow that's not surprising. You have the stated behaviors and attitudes developed from dysfunctional families of origin and they want immediate positive feedback. But guess what? Chronic disease is like family violence. You don't get immediate feedback. In fact, many times there's a lot of negative response—people don't get better and people get angry at you sometimes for asking questions about lifestyle issues that prevent better quality of life.

People who come from that background don't like conflict. And it's very hard to deal with that. And I admit even for me—I have done this for a long time—it's still very difficult sometimes to ask in these situations.

I think that they feel a retribution from the patient; the patient will leave their practice. There's a monetary retribution. They fear that in some way they don't know enough.

There's denial in physicians just like everybody else in the community, just like we heard from the previous three panelists, deny that it really happens. We don't want to know this really happens. It's one of the secrets that we don't like to hear about.

And one of the issues I bring forward is we have to break this "no-talk rule". Leaders like yourself, the media, have to start talking about it. And when we see it like those two hands coming across with the champagne or martini glasses smashing together and then having a skeleton show up in the drinking and driving commercials, when we see that at 8 o'clock time slot, then we know we're doing okay because that's the barometer of when it becomes acceptable to talk about violence.

Physicians don't have a lot of knowledge about violence. Despite all the statistics and information passed out by my colleagues in AMA, most physicians don't read about it. They don't want to know. That has been passed out to me. I have received all the AMA information booklets, and I appreciate them. They're great. They're nice summaries. But in general other physicians don't want to know.

Second, the other part about AMA material that has been passed out, is that it's material on past violence patient presentations after the fact. The AMA materials provide no information on screening. There's no anticipatory guidance information. It's after the fact. When somebody comes in with a black eye, then you do something.

We don't do that with heart disease. That would be like treating heart disease *only after* your first heart attack. We don't do that with lung disease. We ask for early symptoms. We look for it. You look for all the risk issues. We don't do that in the area of family violence.

And it's a sad fact again. We're trying to break a very powerful no-talk rule. That's very difficult.

I think the last part is the physicians' difficulty with the legal system when we do report some stuff like this. I know that I frequently call DHS with the patients that I deal with and I actually say to the DHS worker, even before they say it, "You know, I know you're not going to be able to investigate this case. I just want you to know. And if you have 20 other reports on this maybe you'll do something. I appreciate it."

These people that are overworked and underpaid and have 17 furlough days a year with 20 or 30 furlough days for their senior advisers, they can't do it and we don't support it. And so in our statements is putting tax money as a measure of our support of these things, we've made it very clear. This is not important.

Senator COHEN. And what is your responsibility as a physician once you report it? Do you anticipate having to go to an administrative hearing or a court hearing which will take time from your practice?

Dr. BROWN. That's correct. I was just about to say that. I have been in court many times. I do this a lot. I happen to be subsidized in that I'm given a salary.

Furthermore, physicians can't afford to spend a day or two in court and in the past the courts weren't very sensitive to that and we'd be sitting there doing nothing while waiting in court. And physicians, especially primary care physicians, probably pay a thousand dollars a day just in overhead, to pay the staff and all that. So it's a losing battle.

Second, many times the courts don't do anything about it. The law is really good about finding fault and punishing. It isn't good at protecting. It was never designed to protect in the first place.

And so there's a lot of frustration with the lack of response and feeling—as well as a perpetrator. I feel like another perpetrator when I have evaluated a patient, gone through and dragged up all this mud, to bring it and say that I'm going to call DHS or some other agency that's supposed to intervene and then having that agency intervene minimally because of their lack of staff time and then the patient is sitting there holding the bag, especially when it comes to domestic violence. It's actually put them at more risk when there's no response.

I will skip through the causes except to say that people are susceptible for previous abuse and stresses in the family also set them up in a major way, be it stresses emotionally or economically and—okay. I just want to move on.

Some of the data that I have for Maine, we have some preliminary data. This is not written up yet. This will be presented to a couple of journals, and I thank the Maine Ambulatory Care Coalition and a Dr. Bingham foundation for allowing me to use the information.

Bill Sturrock who is an M.D. who works with me at the Eastern Maine Family Action Residency, Dan Meyer who's down in Augusta at the Maine Department of Family Residency, and Bonnie Post of the Maine Ambulatory Care Coalition and Anne Keith from the University of Southern Maine are people that are doing this work right now. They're looking at just having a screening done on every

patient that enters a bunch of rural practices in Maine, just consecutively, 2 weeks of patients, and they looked at the amount of violence that occurred, and it was staggering.

Sexual abuse history, 27 percent through, you know, from the time of birth basically up to the time of coming into the practice, every single place that was tested; there were three primary care sites and doing some others as well. We're talking 37 to 58 percent of people who have had verbal, sexual, or physical abuse in their history.

We have—at the family practice center, the residency program at Eastern Maine, we screen every female patient because we think that's very important. That's a high risk time for abuse. And well over 14 percent on a face-to-face screening, which always underestimate the positives, have admitted to significant abuse.

So it's here in Maine. It's here and I'm afraid it's here to stay because we don't have the resources to deal with it.

I won't go further with this stuff, but I think it's important that we know there's a whole bunch of different types of abuse as well. It isn't just violence and hitting. It's neglect. I deal with a lot of alcoholic patients that I have experienced finding, having somebody visit their home and finding them unconscious with an 18-month-old or 2-year-old, you know, walking aimlessly through the house. That's not uncommon. Alcoholism is a major factor in this abuse and neglect.

Lack of financial resources, again, that's one of the major issues in neglect. Kids go hungry in this State. We don't like to hear it, but kids go hungry and there's a whole coalition about hunger in the State. We're working very hard at that.

The Department of Alcohol and Drug Ed which has basically been scuttled as far as funding—they did a study in 1988 and actually repeated in 1992, and found that kids know what the problem is. The kids, 32 percent of students in fifth to twelfth grades, realize that a parent in their family has a drinking problem.

Eighteen percent felt alone, scared, nervous, angry, or frustrated because a parent was not able to stop drinking. Thirty-six percent, 36 percent, over a third, felt that they wish that the parent would stop drinking. Kids don't wish a parent would stop drinking unless there's a major issue when they do drink.

Twenty-seven percent stated they were worried about a parent's health because of their use and abuse of alcohol. Sixteen percent had physical symptoms. Eighteen percent, which is not in here, actually stated that they wished they could talk to somebody, and one of the three highest people on the list that they would like to talk to is their physician. But we don't ask.

We do preparticipation sports exams. But, we don't prevent death on the field. We don't prevent injury. What we could do is do better at anticipating guidance and all that, but that's not going to happen. Putting 300 people through in a couple hour period is not good medicine. I see it as malpractice. It's just poor care. But we do that because that's what the schools want.

I actually did a screening a while back. I got fired from the school system. We did a quick history. I told the principal that we wanted to do it, and he agreed, go get information.

Guess what—30 percent of the kids had some sort of alcoholism or violence in their background. Four kids were abuse cases. Four kids were depressed—these were all intermingled, one of which was contemplating suicide. The kids were 11 to 14 years old. This is out of 62 kids we did.

It's out there and it's persistent throughout the system, but we don't want to know about it. I got fired because it's too scary to deal with.

I think that spouse abuse, the same issue. These spouses are—actually I want to expand on that because it isn't just spouses. It's other partners as well, be it divorced people, be it gay/lesbian relationships. We have to look at the whole picture of abuse of significant others.

And I think that this group as well is a group that's walking on eggshells. I couldn't explain it any better than the three that were here before about the intimidation, the fears. But the other things that occur in this population that are abused is they have very similar symptoms to the post-traumatic stress syndrome that we see with Vietnam veterans.

And it's crazy that we think they're going to come up and say, "By the way, Doctor, I have been abused over the last 10 years. I'd like you to do something about it."

Vietnam vets don't do it either, and the reason is because there's all sorts of feelings. There's feelings of inadequacy. They fear it's their fault. If only I had, this wouldn't have happened. There's a lot of self-blame, poor self-esteem.

And we have for some reason expectations that they're going to be different than any other mental health patient who is having an extreme struggle with issues of violence and discomfort, and as well as you just heard, that as physicians, we don't want to hear it.

And if you don't ask the question, one thing about not asking questions is the physician thinks it's not important. If I ask you about your heart, that's important. If I don't ask you about it, it's not important. That's been well shown. Cigarette smoking and other stuff, if we make the statement, "This is hurting you. It's wrong," people actually start doing something about it.

I will just make this shorter. I think that the other thing about this that we forget about bringing back that puzzle, that children who observe spousal abuse are much more likely to be violent themselves. You know, it's not what you say that counts, it's what you do.

If you mentor violence, the kids will do the same thing. We have an intergenerational pattern that has no break and continued abuse throughout the population that I see.

I still have patients who are so conditioned by their experiences as children that—I have a patient who had marks across her face, handprints, and admitted to being slapped and brutalized, and she actually didn't understand that was wrong. That's not uncommon. That's real common.

And I think that if you have no reality testing, if you don't have someone saying that "what's happening to you is wrong," they continue tolerating abuse because this is what my parent taught; I do what my parent teaches me.

Elder abuse is probably the least studied and probably one of the more difficult areas that I deal with because many of the elders that I deal with that are abused are completely dependent.

Many have Alzheimer's and other diseases. It's extremely difficult to get a clear story, as well as there's at least one case worker for all of Penobscot County and, you know, we don't have the resources to deal with it.

There's a whole different—there is a whole gamut of types of abuse, physical abuse, physical neglect, which is a real common one in this area as in children. Psychological abuse, psychological neglect, leaving them unstimulated, you know, in these back rooms where nobody sees them. Material abuse and exploitation, utilizing their funds for other things, family violence in their personal life.

I'm not an expert in elder abuse. I see it and I look for it, and I'm not sure how many people are affected. It's a very difficult area. But I think one of the things I do see and I consider red flag for me is finding families where specifically the elderly person was a past abuser, and I have talked to families and found that out.

There's a much higher risk of neglect and abuse by the family when a family starts taking care of their parent who was previously a perpetrator. And to some extent it's hard to—it's not hard to understand how these people would have difficulty caring, literally wiping stool, doing that for somebody who perpetrated violence upon them.

Other factors that put them at high risk are problem behaviors in elders. Frequently we have elders who get up in the middle of the night. Just like a child who screams in the middle of the night gets abused, the elder that walks scares the individual, overwhelms the person, the people that are taking care of them. It's a high risk area.

Stresses of caretakers, be it previous mental illness or economic stress, high risk factors. And I think that these people have very little help available.

So how can the system respond? Well, the medical system, I wish it could have responded more. I think that we have done a pretty poor job. I hope this is not true anymore, but at least half the medical schools—and I researched it over a year ago—actually had an organized curriculum that dealt with family violence. I hope that's improved, but I'm not sure it has.

And that was usually in an elective format so that very few students partook of that. The only violence that was regularly approached was child abuse, and that was usually part of the pediatrics curriculum but only if a case came in usually. It wasn't very often a major issue with it.

I'd like to commend Eastern Maine Medical Center because they do a really good job educating medical students, but that's a rarity.

I think that it needs to be presented in a real organized way in medical school along with other chronic diseases. Earlier I stated that medical people want immediate gratification. We don't know how to deal with long term illnesses. We have alcohol abuse, family violence, all of which are long-term illness. And I think that we want to have immediate response. We have got to teach physicians that that's not what happens and we can't expect rapid cures.

I have got to tell you that when I brought this up in front of the dean of one of the medical schools, he asked what primary care physicians should be taught, what should we be doing?

I said "First you have got to deal with illiteracy, family violence. You have got to look at substance abuse. You have got to look at how people are motivated to change their habits," and he accused me of wanting to change medical schools into social work schools.

So I told him, "Well, then you don't want to teach primary care people because he is not realistic." That's what we deal with 40 percent of the time. Okay.

So we have to break the no-talk rule with curriculum. We have to be very quick. And one of the keys to that curriculum is attention to attitudinal change. Physicians want to block this stuff. They're not comfortable with it. We have to deal with their attitudes that get in the way.

The Society of Teachers of Family Medicine and the American Academy of Family Practice did a wonderful job doing this with alcohol abuse. There was a 10-part series in a book we taught residents which deals with attitudes. Unless you deal with attitudes, people aren't going to listen. You can send all the books you want. They will sit on the shelf. They will not be read.

We have to learn how to do nonjudgmental interviews, and we have to look at both perpetrator and the victim as people of violence who need help. When I do perpetrator's life experience of abuse screening, I have never found one that wasn't perpetrated upon, and I think they need treatment as well and I think we have to separate them and make sure of safety for the victim.

We have to teach physicians how to deal with evidence, to keep evidence. They're scared to death of the courts, as you previously mentioned. Part of it is just experiencing court, being in court a couple of times getting your evidence thrown out because you didn't do it right and you don't know what you're doing. And there's no reason that can't be taught. It takes all of 20 minutes to teach physicians how to deal with evidence in an appropriate way.

And lastly we have to get physicians as a group and in a large group intercommunicating with the other services, human services and others dealing with primary, secondary, and tertiary prevention.

Primary prevention means teaching people in your community. Physicians in rural areas are seen as the major health information source, and they have got to be the ones that start acting on this and being proactive in bringing it out into the community, break the no-talk rule.

Secondary prevention is looking for populations of risk, going to the schools, talking about it and doing screening. And last is tertiary prevention, and that is dealing with the patients.

I think that a community response has to occur. I think the Indian Health Service did a very nice job of getting a community team together which included school people, police, physician type, social work type, DHS type, looking at them in a coordinated community effort.

Classroom teachers, school systems, early childhood people, they already know who the kids are that are really "out to lunch" and having a really rough time because they're in an abusive situation,

and this has to be coordinated and it has to start very early to pick these up.

There has to be multi-media campaigns that have to be subsidized to really look at this, like I talked about, you know, having 8 o'clock advertisement about this.

Last, there are some programs that have already started to work, although there isn't great data yet. They need to be studied closely.

The Healthy Start program in Hawaii is a proactive program looking at getting paraprofessionals out there and seeing patients who have babies as soon as they have their babies, and following them, depending on their risk factors, on a weekly up to every 6 monthly basis until the kids are older, up to at least 5 years old. That was shown to decrease DHS referral significantly.

Another one is called the Community of Caring which is a values oriented program which we now have in Brewer, and it's a community approach looking at nonviolent resolution of issues and it's, I think, supported by the Joseph P. Kennedy Foundation. And again, these need to be studied to look at what they do effectively, and if they work, what's really good about them.

Last, we have to look at who's resilient. What kids get through this? We have to help these people who have been violated to help them and the best way to help them is to find out what's happened for other people that's really helped them get through and continue on successfully with their lives.

And last, we have to really support, you know, the programs that are actually trying to deal with these patients that DHS people can't be unsupported like it is in Maine and say that we're doing something important like this.

And counseling services have to be made available. The regular wait for somebody who doesn't have insurance right now is 12 weeks here in Bangor. It's pretty hard to refer a violated patient here and wait 12 weeks. That's what it is.

There has to be coordination of care. Hospitals don't know what the other hospitals are doing. We went for a while with no outpatient services because both psych hospitals, major providers, decided they were going to do inpatient at the time.

It's actually bizarre. There's no health planning. There's only sick planning. We have to look at the whole picture. I guess that will do it. Thanks.

Senator COHEN. Thank you.

[The prepared statement of Dr. Brown follows:]

Testimony

of

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Faculty Physician
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TESTIMONY FOR PUBLIC HEARING:

FIGHTING VIOLENCE: HOW CAN OUR HEALTH CARE SYSTEM RESPOND?

U.S. Senator Bill Cohen, Senate Special Committee on Aging

I truly appreciate Senator Bill Cohen for allowing me the time to address the issues of family violence in our Maine communities, a problem too long hidden from the public's eye. As a physician who is interested in the community and medical aspects of this epidemic, I feel relieved that someone of Senator Cohen's stature has found it of primary importance to bring these issues to light to the greater Bangor area community. I will address the topics of child abuse and neglect, spousal or significant other abuse and neglect and elder abuse and neglect.

WE LIVE IN A CULTURE OF VIOLENCE:

I believe it's fair to say that our society has in general failed to define violence as improper or wrong. Sexual violence and physical are constantly on TV. A significant proportion of households feel that corporal punishment both in the home and school are appropriate, and, rightly or wrongly, our government has been involved in acts of confrontation and war which are televised and given an air of heroics rather than a sense of the real pain and trauma of violence associated with war. It takes a community to raise a child and if that community mentors violence as appropriate then growing up children will do violence.

To accurately define violence is to describe it as a disorder of human relationships in which one side attempts to control the perceived weaker side through various forms of abuse and intervention options.

I. CHILD ABUSE AND NEGLECT

A. INCIDENTS OF CHILD ABUSE AND NEGLECT

Child abuse has had medical recognition since 1962 but only over the last 10 years has neglect and verbal/emotional abuse been brought to the forefront as major "abuse" problems. In Maine as in the rest of the country the number of reported cases of abuse

is only a fraction of the true incidence of abuse due to failure to report. In the most recent complete data from the Department of Human Services, the year 1992 brought forth over 16,857 requests for services. Of those, the screened "appropriate referral for child protective services" were 6,675. Having worked closely with the Department of Human Services in this area, we all know that this is the tip of the iceberg. In my own practice, I regularly screen for family violence and abuse and consistently have positive responses to questions about childhood abuse in 25 to 35% of my patients. In our prenatal clinic at the Eastern Maine Medical Center Family Practice Residency Program which serves a large part of Penobscot County, we have found over 46% of our patients have a family history of physical or sexual abuse. The Maine statistics are no different than any of the other States by study or in my discussions with other practitioners. We just have to read the newspapers to see that homicide of children is a major cause of injury and mortality in the infants of our State.

B. DEFINITION OF CHILD ABUSE

The National Center on Child Abuse and Neglect defines child abuse as the "physical or mental injury, sexual abuse, negligent treatment or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare". The people of Maine need to realize that there is not complete agreement on exactly what should be reported as child abuse. When a child is punished by a parent in a manner that leaves bruises, some physicians would not report that injury as abuse. Some feel corporal punishment is justified for "the well-being of the child". "Spare the rod, spoil the child" is still prevalent in some areas of Maine and some court decisions give institutional credence to that saying.

Despite laws in Maine that require physicians to report suspected abuse, physicians fail to report abuse for a number of reasons:

1) They feel their level of knowledge concerning the family situation is inadequate and question or more accurately deny to themselves that abuse is taking place.
2) There is a general fear of losing patients.
3) There is discomfort with confronting a family and dealing with conflict.

4) Many physicians lack confidence in the legal and social systems to do anything appropriate for a child at risk and fear that the legal process will be one more perpetration upon the child with no positive outcome. In our state in 1992, of the appropriate referrals for the Child Protective Services (6,675), there were 1,894 documented as not assigned because of lack of staff. Privately, child protective workers say it is significantly higher. Physicians as well don't understand the legal system; finding it intimidating and its outcomes confusing because many times the results of court proceedings can appear counter-intuitive.

C. CAUSES OF CHILD ABUSE

In Maine, as in the rest of the country, stress is the single most common factor leading to abuse. When coping skills are inadequate, the likelihood of anger and subsequent increases as family stress increases. Other contributing factors include poverty. In the United States, 25% of all children are impoverished. However, one of the greatest fallacies or myths in the area of child abuse is that it only occurs in low socioeconomic status people. Child abuse is nondenominational and has no respect for color, socioeconomic status, education or profession. Psychological problems in the family, especially low social skill levels and low self esteem are correlated with child abuse. Lower educational level is a risk factor. Over the last 25 years social isolation and lack of support systems in Maine as well as substance abuse have been significant risk factors. The extended family living close together with multiple mentors, i.e., aunts, uncles, grandparents, parents, who role model child rearing and who, by virtue of their presence, decrease isolation and pressure upon parents, no longer exists as a majority situation. Lastly, children with special needs and special demands cause increased frustration and are a major risk factor in and of themselves for childhood abuse.

D. CHILD PHYSICAL ABUSE

Growing up in a "culture of violence" as described earlier, breeds intergenerational violence. A society and family that believes in physical punishment reveals to those children

involved that hitting is appropriate as retribution and it is appropriate as a control mechanism in family situations. Children have a rule, "what you say counts little compared to what you do". Children learn from the mentorship of their parents. The severely battered child is at one end of an abuse continuum and we know that abused children are more likely to become child abusers. Boys generally are more likely to be physically abused than girls. Most physical abuse of very young children is perpetrated by the mother who is with them a large proportion of the time and therefore has more contact. The highest risk times are times when the mother and family is stressed in combination with isolation. We observe times that are at particular risk for inciting abuse of very young children: colicky crying babies, night crying, developmental times when food intake decreases, the negative responses of children during "the terrible twos", resistance at early toilet training, self exploration and the early childhood periods which involve separation anxiety. In our interview screening of our prenatal patients, we found over 14% admitted to having experienced child abuse (note: face-to-face interviews have always significantly underestimated the actual experience of patients).

E. CHILD SEXUAL ABUSE

Sexual abuse is defined as any situation in which the child is exposed to sexual stimulation inappropriate for the child's age or psychological development. In Maine as elsewhere in the United States, sexual abuse tends to occur repeatedly over time, typically perpetrated by someone who the child trusts. Sexual abuse of mothers in our residency prenatal screening has revealed a sexual abuse history in 27% of the pregnant patients. (Note again that these were face-to-face interviews which have been shown to generally underestimate significantly the numbers who have experienced such abuse.) Other studies in primary care offices in other areas of the United States have frequently shown rates of childhood sexual abuse between 25 and 35%. Among the experts, it is felt that the degree of reported trauma to the patient is related more to the use of force than to the type or duration of the sexual abuse activity.

F. CHILDHOOD EMOTIONAL OR PSYCHOLOGICAL ABUSE

This type of abuse is the least researched, most hidden and most difficult to define. It is clearly more common than other types of abuse and when severe, it's effects may be more

damaging. There is a saying among people who are trying to recover from the devasation of this type of abuse and it goes as follows: "Sticks and stones will break your bones, but words can break your soul". Examples of emotional abuse include belittling, name calling, criticizing, scorning and damaging treasured objects or pets. It is felt that this type of abuse is more likely passed from generation to generation than physical abuse.

G. CHILD ABUSE BY NEGLECT

This type of abuse occurs by failing to provide the love, care, food, or physical circumstances necessary for a child to grow and develop normally. Some neglect occurs by deliberate choice while much of the neglect occurs out of ignorance of the child's needs or lack of financial resources. Recently, one of these cases was plastered all over the front page on the newspapers throughout Maine. Neglect can kill. Lack of financial resources can be a major source of nutritional neglect in Maine. One of the more common causes of childhood injury in Maine, a type of neglect, is the lack of supervision of toddlers and young children. Substance abuse and other distractions in disorganized families can be a setup for the latter to occur.

With regard to neglect, there is a full continuum. Parents who abuse alcohol or other substances, by virtue of their "anesthesia" may end up being emotionally and sometimes physically neglectful of young children. I have sadly experienced a number of child abuse cases where a parent was found passed out secondary to abuse of substances with very young children unattended in a household for large parts of a day. There have been deaths inadvertently from intoxicated patients rolling onto very young children causing suffocation. Protection of children, especially at young mobile ages, takes constant vigilance and unclouded sensorium. The Maine Department of Alcohol and Drug Education has followed this issue with a number of studies and even the students in the schools of our State are well aware of the substantial alcohol problem that we have here. In these studies 32% of students in 5th to 12th grade believe their parents had a drinking problem and 18% felt "alone, scared, nervous, angry, or frustrated because a parent was not able to stop drinking". 36% felt that they "wish that a parent would stop drinking" and 27% stated they had been worried about a parent's health because of his or her alcohol use. 16% reflected that they had physical systems associated with the worry

regarding a parent's drinking. There is no question that substance abuse and addiction are a major predisposing factor toward emotional abuse and neglect of our children in Maine. Children know substance abuse effects their parents, sometimes making them violent.

H. EFFECTS OF CHILD ABUSE

Most experts feel that those children who are neglected may have the most profound damage to their psychological and social development. These are the patients that end up with the severe behavioral psychological disorders that are extremely difficult to treat. In general, child abuse causes children to develop greater dependency. These children have difficulty coping with stress and frequently have poor capacity for empathy for others. These children frequently have very low self esteem. I believe the latter occurs because of a "rule" of childhood development: "bad things happen to bad people, therefore I must be bad." The latter rule is reinforced throughout the child's life exposure to TV, from cartoons to movies, literary fiction, and TV and radio news exposures. Finally, I believe that the love we learn, e.g., love is hitting, verbally abusing, or sexually inappropriate activity, is the love we know. Thus, the intergenerational perpetuation of the problem of violence and neglect will continue.

II. SPOUSE ABUSE

We use the term spouse abuse loosely because included in that should be boyfriend/girlfriend abuse from teens to the elderly, gay and lesbian relationships, divorced and separated couple violence, as well as marital couple violence. Spouse abuse occurs in multiple forms including:

1) Physical violence, literally assault and battery.
2) Rape and sexual abuse.
3) Emotional/verbal abuse.
4) Psychologic abuse.
5) Economic control.

A. INCIDENCE OF SPOUSE ABUSE

It is sad to say that the experience of spouse abuse in my practice in Maine is quite high: we know that anybody in a marital relationship has a 25% chance that abuse will occur

during a marriage. In our most recent surveys in Maine at rural health centers, we have found that in their lifetime at least 25 to 45% of patients screened admitted to significant physical abuse, 10 to 28% admitted to sexual abuse, and 20 to 30% admitted to verbal abuse. Most patients experience multiple types of abuse. Among the three clinics in rural areas that we have so far tested, total positives for significant abuse ran from 37 to 57%. The one emergency room that we screened in a rural area experienced an overall rate of 58%. In the Eastern Maine Medical Center Family Practice Residency prenatal program more than 11% were experiencing current abuse from their partner. (Note that the latter was on direct interview and therefore is likely to be an underestimation). It is well known that pregnancy can be a time of increased violence between partners and by itself is a risk factor.

B. CHARACTERISTICS OF SPOUSE ABUSE

Despite the myths that lower socioeconomic levels and certain races are where violence occurs, the community needs to know that all socioeconomic levels are involved and in fact sometimes white collar family violence ends up being better hidden because primary care practitioners and the emergency room personnel tend not to screen these patients because they don't fit the stereotype. All races, religions and education levels are also represented. Most violence occurs where it can't be watched and therefore in the privacy of homes. Notably the kitchen or the bedroom is where most spouse abuse occurs. Peak times are known to be around holidays when there are greater stressors typically economic or other family conflict. There have been studies that have elicited the number of significant stressors in a couple's life, and there tends to be an almost geometric rise in violence risk as there is increase in the number of stressors. Poverty is probably one of the major stressors in Maine.

Marital rape, as in other violence, tends not to be a sexual issue but a power issue. In most studies there are 3 to 14% of marriages where this has been documented to occur.

To understand the issues of spouse abuse one must have a sense of the progression of the disease. Most in the field like to break it down into stages:

1) The first stage is characterized by buildup of tension over small issues, resulting commonly in verbal abuse and usually minor physical abuse such as pushing, holding, or blocking the path of the victim.

2) The second stage involves usually an acute battering episode associated with anger and usually significant verbal abuse.

3) The third stage is characterized by a calm period after relief of tension. Frequently remorse is often present.

This cycle repeats itself with battering and more vicious verbal and sometimes sexual abuse occur more frequently and more intensely. Spouse abuse has an insidious quality to it. With slow progression and stepwise progression the comparison to the frog in the slowly heated water is probably a good one. Frogs who are put in very hot water immediately jump out, but slowly heated water will not bring on a response of urgency and thus death occurs. The victim partner in the case of spouse abuse keeps thinking that things will change, in fact, they have the delusion that <u>they</u> can change the way their abusing partner acts and continue in the relationship to their own detriment.

Multiple obstacles are there to prevent the victim partner from getting any help. Women in these relationships feel shame, fear, and guilt about being a victim. I feel a helpful model to understand these patients is post traumatic stress disorder (PTSD). These patients manifest the symptoms and signs of PTSD: they have experienced a numbing of responsiveness and depression that manifests in diminished interest in their usual activities and social contacts causing further isolation. They have feelings of detachment or estrangement which to some extent is a means of coping with the situation. They are frequently "walking on eggshells" and develop an avoidance style of life a strategy they mistakenly think decreases the violence of their partner. A major part of coping with abuse is a constant denial that it's really as bad as it is because otherwise "I'd kill myself!". Many of these women, as in post-traumatic stress disorder patients, have difficulty concentrating and therefore problem-solving skills are diminished. They literally can get to the point where they don't even have the wherewithal to ask for the help they need. We can actually measure memory impairment in patients that are so stressed. Sadly enough, one of the negative factors that delay recovery is the delay or lack of therapeutic intervention in these cases.

Some people feel that these battered women are victimization-prone and that they actually invite the abuse. Studies do not support that. Other obstacles to getting help include some common beliefs in our society; that it is acceptable for a husband to resort to violence to control his wife's behavior. Health care providers don't ask about abuse for numerous reasons that I will get into later and battered women will rarely volunteer the information. As in childhood abuse, similar feelings of unworthiness and powerlessness, a fear of not being believed, a sense of responsibility and guilt for the attack ("if only I had...I wouldn't have gotten him angry and he wouldn't have..."). Finally, many of these victims feel that the attack will be the last one and that the perpetrator will change. These patients, because of such strong denial as a survival tool, albeit self-destructive, end up bargaining and placating the perpetrator. Finally there ends up being a resignation that this is their place in life and feeling totally powerless and these victims acquiesce to the fact that nothing will change and continue to take the path of least resistance as they see it. Note that not uncommonly the husband abuser has control of transportation, money, and even previews all mail coming into the household such that there is a true isolation in female victims. The victim's real fear of retribution for speaking out and trying to get help is all too real.

EFFECTS OF SPOUSE ABUSE

Clearly, the effects of violence in these relationships extends way beyond the immediate physical harm or emotional harm to the victim. the entire family frequently ends up isolated and diminishes in its coping skills. Children who observe spouse abuse are much more likely to be violent themselves. (For children, it's not what you say that counts, it's what you do). Just because children become exceptional students or outstanding in other ways, does not mean that there cannot be significant physical or emotional crises in these families. In fact, it is not uncommon for a child, especially a first child, to be put in a "hero role" in a sense, to show the community that "if I'm doing so well, I can't come from a family that's dysfunctional." Frequently, the older children get put into a parenting role early and end up protecting younger siblings from observing or being a victim of the violence. I interview many survivors of

families of such violence and these patients frequently have long-lasting depressive symptoms, anxiety, panic disorder, poor self esteem, and in general are very confused about what appropriate parenting is. I literally have patients who did not know that being smacked across the face with resulting bruises was inappropriate.

III. ELDER ABUSE AND NEGLECT

Elder abuse is probably the least well studied of all the different types of family violence. "Granny bashing" was first described as elder abuse in the later 1970's and physicians have been slow to recognize the problem of abuse/neglect due to lack of awareness and attention and a paucity of research in this area.

The U.S. population is aging, especially with the balloon of the baby boomers and a larger and larger proportion of our population will be elderly. By the year 2000 18% of our population will be 65 and over. 95% of elderly over 65 years old will live at home.

A. PREVALENCE OF ELDER ABUSE

Elder abuse probably exists with a frequency and rate only slightly less than child abuse. Studies of this area are difficult because many of the elderly cannot speak for themselves and study estimates run from 15-32/1000 population.

B. TYPES OF ELDER ABUSE

I would define elder abuse by the following: Willful infliction of physical pain, injury, or debilitating mental anguish, unreasonable confinement or deprivation by a caretaker or services that are necessary to maintain mental and physical health. There are six categories of elder abuse:

1. Physical Abuse: This refers to direct attacks against an elder person. Also includes sexual abuse and molestation.
2. Physical Neglect: This involves failure to provide the necessities of life, i.e. food, clothing, shelter and medical care. This would also include neglect of proper supervision. Leaving an elderly person unattended who is unable to perform usual acts of daily living, i.e., obtaining their own food, properly taking

their medicines, etc. Caretakers are also responsible for maintaining a safe environment and if a patient was unable to mobilize themselves because of obstructions in the environment which can be as simple as leaving clothing or other objects on the floor which could totally debilitate a Parkinsons' patient from mobilizing out of their bedroom. Lastly, not assisting debilitated elderly patients on self-cleaning and toiletry would also be in this category.

3. Psychological Abuse: Verbal assaults such as screaming or ridicule and threats that intimidate and induce fear are part of this category.
4. Psychological Neglect: This would involve failure of the caretaker to satisfy emotional and psychological needs of a dependent elder. Social isolation or not providing usual social or cognitive stimulation would be involved in this category.
5. Material Abuse or Exploitation - this would involve a caretaker who steals or misuses money or property belonging to the elderly person.
6. Violation of Personal Rights or Exploitation - this would involve depravation of the right to freedom of choice, life and privacy.

C. CAUSES OF ELDER ABUSE

The causes of elder abuse are multi-functional and complex in nature. From studies in family violence, researchers have indicated that family or household stressors that are significantly linked to abuse are as follows:

1. Poor family dynamics such that the elder person had poor past relationships and therefore essentially isolated. Included in this would be the intergenerational transfer of violence, i.e., the patient was a previous abuser of his children and now the roles are reversed.
2. Significant physical or psychological impairment of the elder patient thus they are completely dependent on caretakers.
3. Psychopathology/impairment of the caregiver is a high risk factor especially if they are a substance abuser.
4. Problem behaviors in the elder patient tend to exhaust caretakers, even those with the greatest intentions. At times this leads to isolation and inappropriate confinement of the patient.

5. Internally stressed caretaker: caretakers can feel overwhelmed or isolated especially when there is a lack of community resources in rural areas. The caretaker can also feel external stressors if economic problems manifest themselves, such as job loss or change of job, loss of insurance. In this category a major stressor would be poor health of the caretaker.

Detection of elderly abuse is not easy most times. Elderly persons are frail, many times confused and unable to give a clear history. The elder person, due to fears of reprisal or embarrassment or due to cultural morays, will tend to deny abuse if asked. If an elder feels that their only close relationships are with their caretaker, complaining will be seen as risking perhaps the only person they are close to in the world. Many of these patients are depressed, which may manifest as social withdrawal or anger and primary care practitioners may find the attitude of the patient a "turn off". Physicians may feel frustrated by the lack of positive interaction with these patients.

IV. HOW CAN THE HEALTH SYSTEM RESPOND?

I am embarrassed to say that the medical system in general has done an extremely poor job in preparing physicians and other caretakers to respond to issues of family violence. There is significant resistance within the medical education system because they are uncomfortable with social research in that there are too many variables and its seen as "muddy" research. Material that gets presented in medical school is totally biased by the people who are researching in that institution. Only half of all medical schools mention anything about family violence in their curricula. Of those that do, most only talk about child abuse. Frequently the topic is presented in an elective class format reaching only a very small percentage of a medical student class.

Approximately a year ago, a number of physicians from the Eastern Maine area were invited to meet with a Dean from an associated medical school in regards to ideas about stimulating physicians to choose primary care as a career. When I discussed some of the issues that I thought should be presented more strongly in medical school such as family violence, illiteracy, and issues regarding better physician understanding of patient motivation, I was told "I will not turn our medical school into a social work school". Many of our institutions teaching our

caretakers are reluctant to change 50 year old traditions of classical medical training despite the generally well-recognized statistic that 40% of what we see in outpatient practice is complicated by family violence, substance abuse, and other psychosocial issues.

Many physicians are also intimidated by the issues of family violence because it's "too close to home". Medical schools and other caretaker training programs have students that at least equal the general population with their own personal experience of family violence and neglect. I actually believe that the proportion is higher in medical personnel.

A. Medical Training

All medical schools and residency training programs, nursing schools, physician assistant nurse practitioner schools and all other paramedical systems training need to have the issue of family violence and substance abuse institutionalized into their training curriculum. The issue needs to be openly addressed as opposed to a hushed sidelight or passing interest. There are many similarities in the needs of family violence curriculum to what are already well-established substance abuse curriculums which include the following:

1. Curricula need to break the "no-talk rule". Training must allow an environment that is safe to openly discuss difficult social issues instead of following the current norms of minimizing and relegating its' importance as interest only to a fringe group. This includes having small group discussions which allow individuals to process their own issues and biases because of their own family backgrounds which include some of these issues. Until individuals in these fields recognize their own attitudinal obstructions to dealing with this issue, they won't be able to promote effective intervention.

2. We must require formal training on how to do proper non-judgemental interview evaluations, appropriate and complete exams, and teach skills of proper collection and maintenance of evidence.

3. Curricula should teach and promote proper screening for family violence from birth to geriatrics patients as a routine health maintenance item; to include and, in

fact, emphasize the prenatal period in pregnancy. To do this requires that multispecialties who are not used to considering primary care issues like family violence get involved and become at least adequately trained to screen and triage these patients. One of the pitfalls in medicine is that many times these issues of health maintenance wait for a "routine history and physical exam". The latter is a rarity and these issues must be screened for during acute medical visits. Violence is an issue that most times will not present with casual screening but is more likely to be divulged at the time of acute pain and suffering which has resulted from the problem of family violence. Medical training must put a much higher priority on prevention activities of primary care practitioners. Primary prevention involves prevention by educating patients on either a one-to-one level and educating the general population, e.g., through school programs, community awareness campaigns, and presenting to legislators, i.e. supporting specific education to prevent family violence. Physicians are frequently seen, especially in rural communities, as the major source of health information and therefore, they need to feel more comfortable being involved with multimedia presentations of difficult issues such as family violence.

Secondary prevention for family violence issues would entail physicians screening for specific risk factors thus identifying specific populations at risk. Thus, educating these individuals at risk on a one-on-one or group or community basis as an early intervention to promote skills which will counter the risk factors that predispose to family violence. A key period in the life cycle, a time when patients are more open to violence intervention and counselling, can be parenting periods. Patients tend to be more open to social support networks which can do anticipatory guidance and counseling for these patients and families at risk.

Tertiary prevention by primary care deliverers would be to maintain good follow-up and teaching of patients who have either experienced or perpetrated abuse. This would include managerial reporting to designated social services programs which may mean being involved in the process that removes vulnerable patients from unsafe environments. Physicians will need to support

ongoing support groups that help both victims and perpetrators, e.g., Parents Anonymous, Alcoholics Anonymous, Al Anon, incest and violators recovery groups.

We need physicians and other primary caretakers involved with primary care research around the issues of family violence. Currently, the Maine Ambulatory Care Coalition has a Family Violence study group which is doing ongoing research albeit dismally funded and therefore slowly progressing. (The previous materials that I presented as Maine's statistics regarding the issues of family violence came from the Maine Ambulatory Care Coalition study groups by permission of Bonnie Post, Dan Meyer, PhD, and William Sturrock, MD.) Such community-based systems approaches to these studies should be strongly encouraged and given monetary support. Medical schools need to involve themselves in more primary care research such as that done by the Maine Ambulatory Care Coalition. Note that one side effect of doing this research at local clinics has been that awareness of the practitioners in those clinics, just by having done the patient questionnaires, has increased markedly. Those affected practitioners are now changing their behavior and their approach to family violence issues.

B. Community Response

Similar to the needs of medical personnel, community personnel who are interfacing families on a regular basis need to be trained as "first responders". Police and other social service personnel frequently face family violence issues in homes throughout their communities. To be effective, these individuals need similar sensitization training as those in medicine to be able to comfortably deal with the issue of violence and be more effective in the intervention process. There is precedence in some communities in the Indian Health Service of developing a community team made up of police, medical, social, school and other community personnel who help generate a community approach to the problems of family violence. Sadly, the Maine government stopped funding the local community suspected child abuse and neglect committees.

The Maine Department of Alcohol and Drug Ed used to have an excellent program which developed community teams to intervene in an integrated way regarding the issues of substance abuse and family violence issues. The process involved was extremely effective in that they taught the teams a stepwise approach to changing community, and therefore individual, behaviors. The

stepwise approach included initial education and awareness, the interactive community processes which helped developed an open climate to discuss the issues around family violence and substance abuse, integrating a curriculum in the school systems and adult education systems, developing and supporting support groups and systems support that are accessible to the community and finally promoting professional and school team intervention systems to be integrated with the former steps. This program, as well has been scuttled by severe funding cuts in this State due to the recession. Only a skeleton program was left and over 50 community teams are withering away through lack of support. Many programs like this, to be effective, require constant support from a central group that is expert in the area of community intervention. Maintaining such teams requires an ongoing program to educate newcomers to the team because of the expected personnel turnover.

There are some programs that have been trialed in the United States and have shown significant success. These programs need national support and research regarding their long-term effects. One such program is Healthy Start. Healthy Start was developed in Hawaii and is a program that is designed to improve family coping skills and functioning especially regarding the areas of parent/child interaction by using paraprofessionals in an "early identification" process. Caseworkers are assigned to every family where there is a birth and families who have positive risk indicators are visited frequently in a proactive way to help them cope with strassors that frequently lead to violence and/or neglect. Another such program is one supported by the Joseph P. Kennedy Foundation and its called "Community of Caring". One such pilot is now just being started in one of the Brewer, Maine schools. Community of Caring is a process that's initiated in the schools but is a community-wide, values-oriented, program that looks at alternative choices to violence and high-risk behaviors through a total community effort to promote self-respect and self-esteem.

Because family violence is so prevalent, we need a competent and well-supported Department of Human Services protection system. Caseworkers in our current system are dedicated and well-skilled but are so overwhelmed by their case-load that their effectiveness is markedly reduced. Currently in Maine, somewhere between 80 and 90% of all child protective reports are triaged out, not because they shouldn't be evaluated, but because there

is insufficient staff. What is left are the cases that are so extreme that immediate and emergent intervention must occur or the risk of deadly violence or severe psychological harm is inevitable. This leaves the Department of Human Services caseworkers to deal with only the "conflagrations" vs. proactive secondary prevention efforts to prevent these disastrous situations from occurring. Federal, State and local governments need to appropriately fund these agencies. I dare anybody to run a business with all of the staff having 17 furlough days above and beyond their usual vacation and supervisors who have enforced upon them even a greater number of furlough days as is currently the case in Maine.

I would also propose to have the Child Protective Services were the children are. It makes much more sense that child protective caseworkers be located in school systems and therefore more locally positioned to effect early intervention in families at risk. The Headstart people, the school teachers, and school guidance counselors invariably can predict which children come from significantly dysfunctional households within the first month of attendance at their school systems. If the Department of Human Services could integrate their caseworkers with these other professionals who have constant interaction with children in the communities, as well as police and other first responders in a team approach, I feel that the enhanced effectiveness toward primary, secondary and tertiary prevention of abuse could be profound. Having child protective caseworkers seen as local advocates for children in a positive way and more available would also make their own role much more satisfying as well as more effective and perhaps decrease the turnover rate of caseworkers. Currently, child protective caseworkers' jobs are mostly thankless, institutionally set up for failure and not supported financially or emotionally by the current system.

I believe that local placement of Department of Human Service caseworkers would also enhance primary, secondary and tertiary prevention of elderly abuse. Accessibility and proactive education programs which help develop a climate of more open communication is the key for vulnerable elderly patients. A program oriented towards prevention of elderly abuse similar to Healthy Start as described above, could be an effective intervention tool. The same paraprofessional visiting caseworkers could do both.

Lastly, there must be more access to trained counselors and support group facilitator personnel. In this area of Maine there is no coordination of counseling services. An example of that was recently noted when the Acadia Hospital, a new psychiatric hospital, decreased its outpatient counseling support at the same time that the major other counseling system did the same. Both organizations focused personnel resources in developing new inpatient units. Suddenly, there was a dearth of outpatient counselors and an unacceptable waiting period for families in crisis, i.e., 12 weeks before a counselor could do an intake. It is of paramount importance that government systems keep track of the available resources and promote appropriate availability and integration of counseling resources.

V. NATIONAL HEALTH POLICY

The above-mentioned areas regarding family violence need to be emphasized in the national health policy. National programs needs to promote cooperation and integration across public health care, mental health, criminal justice, social service, education and other relevant sectors. National systems have to promote research and develop accessible and available quality data on morbidity/mortality in violence. The current data is uniformly poor and scattered. National policy must promote effective services for victims that address physical and psychosocial consequences of violence. To do this will require better research regarding what are the real consequences of violence and as well research regarding what makes certain individuals more resilient to the effects of family violence. Efforts to prevent the problems of alcohol and illicit drug use need improvement, both prevention policies and better promotion of medical/psychological intervention for recovery. Professional education and awareness in identifying and treating perpetrators and victims of violence must be promoted on the national scope. Federal pressure must be placed on physicians to be more accepting of these issues and that training must include addressing attitudinal obstructions and solid training of primary care providers including risk factors and appropriate intervention and triage of victims of family violence. Other community personnel need to be trained as well and certainly any individuals in the social service areas must be skilled in the area of family violence. Lastly, of paramount importance is the respect for cultural differences and values and behavioral norms in the many different ethnic and racial groups in the United States must be maintained. Studies must consider these issues as well.

Senator COHEN. Dr. Fishwick.

STATEMENT OF NANCY FISHWICK, Ph.D., FNP, FAMILY NURSE PRACTITIONER AND ASSISTANT PROFESSOR, UNIVERSITY OF MAINE SCHOOL OF NURSING

Dr. FISHWICK. Thank you. I am pleased to represent nurses in this hearing on family violence in Maine because nurses in all clinical settings encounter the victims and the perpetrators of family violence.

Initially clinical focus was on emergency room settings and focus started to include prenatal care settings, but we now understand that in all kinds of settings we're encountering people who are living with violence.

Along with all other health care professionals, we have often overlooked the abuse in the lives of the people we serve either through being uninformed about the issue, being naive about the extent of the problem, or perhaps being unable to deal with another person's pain because we are struggling with violence in our own home.

We have therefore contributed to the problem by sending people home as isolated and uninformed as they were when they came to our attention. And it is very unfortunate because health care visits could provide important opportunities to begin to break the isolation, to explore options for safety, to provide accurate information about community resources, and to offer support for the difficult decisions that must be made.

My own commitment to understanding family violence and the abuse and battering of women actually arose from clinical work in eastern Kentucky in a rural primary care service several years ago. This was an isolated setting that allowed continuity of care and the opportunity to know one's clients very well.

One day while I was performing a physical examination on a woman who I thought I knew very well, I made a passing comment about a fading bruise, and that casual comment brought forth a story of abuse and assault from her husband of many years. Needless to say, I was quite stunned by this revelation, and I was very uncomfortable because I did not know how to respond to this information.

My own graduate education did not include information about domestic violence. It did include information about recognizing and responding to child abuse, but it predated public awareness of domestic violence and elder abuse.

So that one typical clinical experience really led to my own self education on the topic of domestic violence, and I reformed my own clinical practice and I became actively involved with grass roots domestic violence shelters and programs, first in Kentucky where actually there were none where I was working and became involved with establishing a shelter, later in Cleveland, Ohio, and now at Spruce Run in Bangor.

Since living in Maine, I have learned that women in rural Maine face enormous challenges when they attempt to end the abuse in their lives, and their success will depend on overcoming difficulties such as geographic isolation from services, lack of accessible services for battered women and their children, and very limited oppor-

tunities for women's higher education and employment and affordable housing.

Last summer I did complete dissertation research on battered women's experiences in health care settings. The women I interviewed—now, this was in another State—had stories very similar to the ones you heard this morning from Roberta, Grace, and Sharon.

From these in-depth interviews I learned their reasons for disclosing or concealing their abuse to nurses and physicians. The leading reason far and away was fear that the disclosure would lead to an official investigation of some kind which would place them at further risk for harm from their abuser. Women knew often from past experience that no protection order or police officer could realistically protect them from the abuser.

Second, they had an associated fear that with an official investigation, they would somehow become labeled an unfit parent and their children would be removed from the home.

And third, women had a strong perception that health care providers either simply would not be of any help to them or that they simply did not care about their plight or, even worse, that they might react in a very harsh way to information about the abuse.

Women who did choose to disclose usually did so simply for the sake of having medical record documentation for future prosecution. And of those who did disclose, only a small fraction received what they felt was a concerned response, and an even smaller fraction received any particular information about community resources.

I'd like to summarize a few other key impressions from the interviews and also those that went into recommendations to health care providers. First, although not every health care visit may have been directly related to the abuse in a woman's life, every health care visit did in fact set the tone for her decision to turn to or to avoid health care providers in the future when she may be seeking assistance for abuse.

Second, women believed that health care providers held a great deal of power to assist them or to ruin them if information about the abuse became known. Those women who disclosed realized they were taking a risk that the information would not be held confidential and that their safety would be jeopardized.

Third, women were more likely to disclose to someone that they perceived as nonthreatening in the health care setting such as a nurse, a nurse's aide, or a receptionist rather than to a physician.

And this is consistent with what is known about disclosing any kind of stigmatizing information. People are more apt to disclose to someone of equal or lesser power or social status than they are to someone of higher power or social status.

Senator COHEN. Or to someone who might be more sympathetic?

Dr. FISHWICK. Perhaps, and also those roles that I mentioned tend to be female as opposed to male.

Nevertheless, this reminds us to include family violence and domestic violence in all curricula including nurse's aide curricula and other supportive health personnel.

Fourth, women's recommendations to health care providers were very modest. When they did turn to us for assistance, they were

looking for more than remedy of physical injury. The types of assistance they were hoping to receive included emotional support, accurate information, links with community resources, and medical record documentation.

I have learned however that some insurance companies in other States have been using medical record documentation for domestic violence as a reason to deny a woman health coverage, and that's of grave concern.

Last, women also requested respect of their decision to disclose or to conceal their abuse. They cautioned us to be cognizant of the very precarious circumstances a woman may be in and to allow her to be the best judge of her situation at any given time.

Since my own enlightening experience 14 years ago, I have seen the positive effect of a few dedicated movers and shakers in the fields of nursing and medicine and public health, and domestic violence and family violence in general is now viewed as a health problem as well as a social and criminal justice problem.

In recent years all our professional societies like AMA and American Nurses Association among them are mandating attention to domestic violence in clinical settings and in our educational programs and in research. However, research demonstrates that the national mandates have not yet been achieved in actual daily clinical practice.

I believe it will be relatively easy to educate health care providers about the prevalence and the health consequences of abuse and even to assess women for abuse, but I also believe it will be very difficult to influence the attitudes and beliefs that undergird the provider's response to abused women.

Disclosure is a privilege that carries tremendous responsibility to respond thoughtfully and helpfully. Furthermore, the provider's response to abuse must take the form of advocacy and collaboration with women rather than the traditional therapeutic prescription or advice giving to women. That will involve a significant shift in the way the doctor-patient or nurse-patient relationship is often played out.

In conclusion I offer some recommendations for educational programs and the clinical practice of health care professionals. First, I would urge that the topic of domestic violence and all forms of family violence be included in nursing and medical curricula.

In nursing programs in particular, the content would be included in undergraduate and graduate levels, especially in the areas of women's health, care of children, care of the elderly, community health, and primary health care which is usually a nurse practitioner specialty.

I would caution that components of the educational process need to include more than didactic content, the nature and the extent of domestic violence. It must include development of interpersonal skills to promote disclosure of abuse and to respond in a helpful manner.

Furthermore, it must include staff or volunteers of local domestic violence programs for assistance in curriculum development and in class sessions regarding community resources such as shelters and support groups.

Second, I would suggest that the topic of domestic violence and all forms of family violence be included on our national licensure and our advanced certification examinations for nurses, physicians and other health professionals.

Third, I would also like to recognize that victims and perpetrators of domestic violence as well as other family violence are within our professional ranks. Personal experience with family violence either as a victim or a perpetrator affects one's response to clients who are living with abuse, and therefore I would urge that the educators of nursing and medical programs as well as clinical administrators be provided with education about domestic violence to increase their ability to detect and respond to staff or students who are living with violence in their homes.

Fourth, as a health care community, I would like to see us work to discourage legislative efforts that would require medical personnel to report known or suspected domestic violence in the way that the reporting of child abuse is currently mandated. Though well intentioned, such reporting would bring women's worst fears to life and would discourage their disclosure of abuse to nurses and physicians and, worst of all, may result in their avoiding health care settings altogether.

Fifth, I would urge fostering alliances among health care services, nursing and medical educational programs, local domestic violence programs, law enforcement, criminal justice, and other people in direct service with domestic violence.

And last, I fear that if our efforts succeed, we will be increasing the detection of abused women, which means that shelters, hotlines, and support groups which are already stretched to the limit in terms of personnel and limited budgets are going to have additional demands placed upon them.

And therefore I would urge health care agencies and educational programs to contribute to the security of local domestic violence programs through financial contributions, donations of goods, volunteer services, and also support of legislation that would allocate additional funds to domestic violence programs such as the Violence Against Women in the Anti-Crime Bill.

Thank you again for this opportunity to be part of this hearing.

[The prepared statement of Dr. Fishwick follows:]

Senate Special Committee on Aging

Field Hearing on Family Violence in Maine

Testimony of Nancy Fishwick, PhD, FNP

June 20, 1994

Bangor, Maine

My name is Nancy Fishwick. I am a family nurse practitioner and an assistant professor at the University of Maine School of Nursing in Orono. I am pleased to represent nurses in this hearing on family violence in Maine.

Nurses in <u>all</u> clinical settings encounter victims and perpetrators of family violence. Along with all other health care professionals, we have often overlooked the abuse in the lives of people we serve through being uninformed about the issue, being naive about the extent of the problem, or being unable to deal with another person's pain because we may be struggling with violence in our own home. We have, therefore, often contributed to the problem by sending people home as isolated and uninformed about options as when they came in. Health care visits <u>could</u> provide important opportunities to begin to break the isolation, explore options for safety, provide accurate information about community resources, and offer support for the difficult decisions that must be made.

My commitment to understanding family violence, and abuse and battering of women in particular, arose from clinical work in a rural primary health care service in eastern Kentucky 14 years ago. The isolated setting allowed continuity of care and the opportunity to know one's clients very well. One day, while performing a physical examination on a woman I <u>thought</u> I knew well, I made a casual comment about a fading bruise on her arm. My offhand comment brought forth her story of abuse and assault from her husband of many years. I was stunned by her revelation and very uncomfortable because I did not know how to respond to this information. I did not understand the nature and complexity of domestic violence, the cultural and logistical obstacles that keep women trapped in abusive relationships, the effect of domestic violence on the health of women and their children beyond physical injuries, nor the community resources available to assist women achieve safety. My graduate educational program had included content on recognizing and responding to child abuse and to sexual assault victims, but predated public and professional awareness of other aspects of family violence such as abuse and battering of women and abuse of the elderly.

That pivotal clinical experience led to self-education on the topic of domestic violence, reform of my own clinical practice, and active involvement with grassroots domestic violence programs and shelters. Since living in Maine, I have learned that women in rural Maine face enormous challenges when they attempt to end the abuse in their lives. Success depends on overcoming difficulties such as geographic isolation from sources of help; lack of accessible services for battered women and their children; and limited opportunities for higher education, employment, and affordable housing.

Last summer I completed dissertation research on battered women's experiences in health care encounters. From in-depth interviews with women in abusive relationships, I learned their reasons for disclosing or concealing their abuse to nurses and physicians. The leading reasons included:

1. Fear that disclosure would result in an official investigation of some kind which would place her at risk for further harm from her abuser. Women knew, often from past experience, that no protection order or police officer could realistically protect them from their abuser.

2. An associated fear was that the official investigation would declare her an "unfit parent" and her children would be removed from the home.

3. Perceptions that the health care provider did not care about her plight or would react in a harsh, judgmental manner to information about the abuse.

Women who did disclose usually did so for the sake of having medical record documentation for future prosecution. Only a small fraction of the women who disclosed to a health care provider received a concerned response and an even smaller fraction of women received any information about community resources.

I would like to summarize key impressions from the interviews and women's recommendations to health care providers:

1. Though any particular health care visit may not have been directly related to the abuse in a woman's life, the overall tone of the interaction set the stage for future decisions to seek help from, or to avoid, health care providers.

2. Women believed that health care providers held a great deal of power to assist them or to ruin them if information about the abuse became known. Women who disclosed ran the risk that the information would not be held confidential and that their safety would be jeopardized.

3. Women were more likely to disclose to someone they perceived as nonthreatening in the health care setting such as a nurse, a nurses' aide, or a receptionist rather than to a physician. This is consistent with the literature on disclosure of stigmatizing personal information; people are more likely to disclose to someone of equal power or social status than they are to someone of higher power or social status. This reminds us to include family violence and domestic violence in the curricula and continuing education programs for nurses' aids and other supportive health personnel.

4. Women's recommendations to health care providers were modest. When they turned to health care providers for assistance, they expected more than remedy of physical health problems. Emotional support, accurate information, links with community resources, and medical record documentation were the types of assistance women expected to receive. No one expected the health care provider to "fix the problem" for them.

5. Women also requested respect of their decisions to disclose or conceal the abuse. They cautioned health care providers to be cognizant of the precarious circumstances a woman may be in and to allow her to be the best judge of her situation at any given time.

In the past 14 years, I have witnessed the positive effect of a few dedicated "movers and shakers" in the fields of nursing, medicine, and public health in reframing domestic violence as a public health problem as well as a social and criminal justice problem. In recent years, our professional societies and associations have mandated attention to domestic violence in clinical settings, educational programs, and in research. However, research demonstrates that the national mandates have yet to be achieved in routine clinical practice. For example, several studies of women seen in emergency departments found that domestic violence was the leading cause of injury to women. For the most part, however, the abuse was not recognized or addressed by those who took care of those women. There is little recent data regarding standard practice in primary health care settings, but past experience suggests that we have been equally remiss in ignoring abuse, or worse, labelling and medicating women for mental health problems when abuse was the crux of their symptoms.

I believe it will be relatively easy to educate health care providers about the prevalence and health consequences of abuse and even to assess women for abuse, but it will be very difficult to influence the attitudes and beliefs that undergird the provider's response to the abused woman. Disclosure is a privilege that carries tremendous responsibility to respond thoughtfully and helpfully. Furthermore, the provider's response to abuse must take the form of advocacy and collaboration with the woman rather than the traditional therapeutic prescription or advice-giving to the woman. This involves a significant shift in the way the doctor-patient or nurse-patient relationship is often played out.

In conclusion, I offer the following recommendations for educational programs and the clinical practice of health care professionals. The recommendations are based on clinical experience, knowledge of the literature and programmatic efforts in other parts of the country, and work with the victims and survivors of domestic violence. The recommendations all require resources in terms of people and time, and therefore would only succeed with federal, state, and institutional support.

1. Include the topic of domestic violence, and all forms of family violence, in nursing and medical curricula. In nursing programs, the content would be included in undergraduate and graduate levels, particularly in the specialty areas of women's health, care of children, care of the elderly, community health, and primary health care. Components of the educational process should include:

   a. Didactic content regarding the nature, extent, and health consequences of domestic violence for women and their children.
   b. Development of interpersonal skills to promote disclosure of abuse and to respond in a helpful manner, specifically advocacy rather than advice-giving.
   c. Provision of field experiences that illuminate the complicated process of leaving an abusive relationship. For example, accompanying women to court when they are prosecuting their abuser, to learn of the criminal justice process related to domestic violence.
   d. Inclusion of staff or volunteers from local/regional domestic violence programs for assistance in curriculum development and in class sessions re: community resources such as shelters and support groups.
   e. Foster on-going alliances between educational programs and grassroots movements for social change.

2. Include the topic of domestic violence, and all forms of family violence, on national licensure and advanced certification examinations for nurses, physicians, and other health care professionals. Curricular changes will certainly follow.

3. Recognize that victims and perpetrators of domestic violence, as well as other forms of family violence, are within our professional ranks. Personal experience with family violence, either as a victim or perpetrator, affects one's response to clients who are living with abuse. Therefore:

   a. Provide education for nursing and medical educators and administrators regarding domestic violence.
   b. Increase educators' and administrators' ability to detect and respond to students or staff who have lived, or are still living, with violence in the home.
   c. Provision of support and/or referrals for students or staff who have lived, or still are living, with domestic violence.

4. Discourage legislative efforts that would require medical personnel to report known or suspected spouse abuse in the way that reporting of child abuse is currently mandated. Though well-intentioned, such reporting would bring women's worst fears to life and would discourage their disclosure of abuse to nurses and physicians and would, perhaps, result in their avoiding health care settings altogether.

5. Foster alliances among health care services, nursing and medical educational programs, local domestic violence programs, law enforcement, criminal justice services, clergy, and interested others. Health care services should contribute to the expansion of current resources and/or development of new resources as identified by the alliance.

6. Increasing detection of abused women means that shelters, hotlines, and support groups, which are already stretched to the limit in terms of personnel and limited budgets, will have additional demands placed on them. Therefore, health care agencies and educational programs must contribute to the security of local domestic programs through financial contributions, goods, and services.

Thank you again for this opportunity to address ways in which the health care community may improve its response to Maine women who are involved in family violence.

Senator COHEN. Thank you very much, Dr. Fishwick.

Mr. McLaughlin, could I ask you—you have been sitting patiently—to summarize your printed remarks? We have one more panel to go and I have to catch a plane back to D.C. I want to make sure that everyone has a chance to talk. But, please, if you could give a summary of the key points you would like to make for the panel, for the Committee, the full statement will appear in the record.

STATEMENT OF ROBERT McLAUGHLIN, COUNSELOR AND CHAIRMAN, HEALTH CARE RESPONSE COMMITTEE, MAINE COMMISSION ON DOMESTIC ABUSE

Mr. MCLAUGHLIN. Yes, Senator, I plan to do that.

Senator COHEN. I noticed you were making notes.

Mr. MCLAUGHLIN. Your staff have been very clear. I didn't intend to put it in at all.

We can't do what we don't know how to do. That's the main point I want to make during my remarks.

One thing that's been illustrated by the three medical health care professionals, there's certainly a learning process that medicine and those in the health care role currently rely on almost solely to teach health care practitioners and providers about this subject, and that is individuals will become inspired. That's how I learned.

I became inspired 27 years ago by a woman who told, whose story I witnessed in a way that women on the first panel shared their stories. I'm grateful to her and the whole procession of women that have taught me what I know. That's how I know what I know.

There's another term of art. Eric mentioned a term of art: "within normal limits." There's a corollary term of art in medicine which is "remarkable." When something is not within normal limits, it's remarkable.

These are three remarkable individuals here with me who have chosen to learn and chosen to change their procedures and chosen to go out in the world and try to help change others.

That learning process will not suffice for the entire body of health care providers in the United States. And so as I did in my written testimony, Senator, I really focused my remarks on specific recommendations for what I think the Nation should do.

I will simply read those three paragraphs so that part of my testimony is clear.

First I am recommending authorization and appropriation of at least $50 million to be made available to the States to begin the task of retraining existing health care providers in the clinical skills required to identify and effectively respond to the 25 to 35 percent of unidentified women health care patients in America who are being abused in their domestic relationships.

These funds should be used to provide systematic and comprehensive retraining of existing health care providers to identify and effectively respond to abused women and their children in all health care settings in ways that will prevent and reduce the abuse which injures and damages them at such high rates every year.

To be effective, this retraining program must be based on adult learning principles. It must extend over a 2- to 3-year period at

least during which the skills of identification and effective response to woman abuse are learned, evaluated, consolidated, and supported.

It should include an evaluation and research component for each State which measures the increase in effective health care response and reports it in ways which validates and supports the changes which are expected in the behavior of health care providers and teaches all of us more about how to train and respond more effectively.

Second, I am recommending that no further time be wasted in limiting Federal funding of public health responses to domestic abuse of women to small demonstration programs over 3-year funding cycles.

I am extremely grateful for the two tiny Federal demonstration programs of public health responses to woman abuse which are about to begin, one sponsored by the Centers for Disease Control, the other by the Bureau of Maternal and Child Health.

These represent the first Federal public health initiative on woman abuse. I recognize and deeply appreciate the leadership represented by these programs, but they are woefully inadequate.

As a Nation and as a health care community, we are way past the need to demonstrate the need for a public health response to domestic abuse of women. We have more than enough information and national experience to warrant full funding for a comprehensive national public health initiative to health care providers who know how to identify abused women who come to them, abused women who come to them for health care services and who know how to respond effectively to help prevent, reduce or stop further abuse; and that's why we need it.

And I want to add that John LaCasse, president of Medical Care Development, Inc., who applied for the Centers for Disease Control program for Maine; and Bonnie Post, Executive Director of Maine Ambulatory Care Coalition, who applied for the Bureau of Maternal and Child Health program, both agree with these proposals.

Third, I recommend that Federal legislation create the mandates and incentives required to ensure that all primary and secondary training programs for health care personnel provide comprehensive training in these clinical skills as a condition of program accreditation and to ensure that all States require competence in these clinical skills as a condition of licensure for all new health care providers.

Finally, I am recommending that significant new funding on both a State and national level be provided for shelter and advocacy programs for abused women—in order to help provide the training which health care providers require; in order to extend the services of shelter and advocacy programs to meet the current unmet needs of abused women and their children; and in order to extend their services to meet the dramatic increase in demand which will result when health care personnel become trained to identify and effectively respond to domestic abuse of women.

One of the reasons I think it is so vital to move in this way, Senator, is because we have more than enough evidence to show that other ways of teaching, the learning tools we are appealing to in the health care profession is a process that isn't working.

In 1976, Dr. Susan McLeer at the Women's College of Pennsylvania instituted one of the first hospital protocols in emergency departments for battered women.

She did that after doing a retrospective study of charts in the ER showing that 3 to 5 percent, only 3 to 5 percent of women who clearly showed evidence of physical and emotional, psychological effects of abuse had been identified during the previous year of 1976.

She wrote a protocol. It was adopted. She trained the ER personnel in support of it, and the number of identification from a similar sample for the next year rose to 30 percent.

So it was made clear that you can do things to increase the responses to abused women. Eight years later she came back to that emergency room. Between those two dates she led an initiative that resulted, in 1992, in the Joint Commission on Hospital Accreditation (JCOHA) mandating all hospitals in America to have such a protocol.

However, she came back to that original ER 8 years later. She demonstrated in a new piece of research that, although the protocol was still on the books, identification rates had dropped again to about 5 or 7 percent.

This led to a new article in the literature by Dr. McLeer making the point that education is not enough and that we need all hospitals to be required to have protocols. Accordingly, since January 1993 the JCOHA has required such hospital protocols. Sadly, I must report that protocols will not be enough either.

In 1986 I initiated a group at a major hospital in Maine and wrote the first hospital policy in Maine to address the abuse of women. We trained. It was enacted as a policy. We trained staff. Same life history: 8 years later, the protocol is still on the books. But, identifications on chart reviews that were done—only 5 percent.

This story of what I call a "hollow protocol" is sad enough. But it gets sadder. A few weeks ago Maine newspapers announced that this hospital had been re-accredited by the Joint Commission on Hospital Accrediation. This demonstrates that the Joint Commission only requires hospitals to have procedural protocols on domestic abuse. It doesn't require them to use them. It doesn't require them to know how to use them. It doesn't require them to change the knowledge base, the behaviors and the performance of their health care providers in response to abused women. It doesn't require them to increase identifications of abused women. And it doesn't require them to make effective responses which would decrease injury and death from abuse among American women.

So the protocol process isn't working. And to that extent I disagree with Dr. McAfee—protocols will not get the job done. We need to make funds available for primary and secondary training of all health care providers. We need to require that it happens.

The final thing I want to mention in my, hopefully, brief summary here is that—a point I'd like to make in response to Eric's testimony. I admire Eric tremendously. I admire his work tremendously.

But his testimony also illustrates something that is a serious problem but which I don't blame him for. It comes out of his training. Domestic abuse of women is not an illness. It is injury and

damage as a result of behavior choices by people who abuse those women.

It would be very dangerous for us personally in this Nation to begin calling it an illness. I don't have time to explain in detail what behaviors, personal and social and political, result when you adopt that language and that understanding of it, but it's dangerous to women. It's dangerous to victims of abuse to adopt that language.

You must keep clear as to what abuse is. In the rest of my written testimony I have tried to make that clear and explain the names we should use for what we are talking about.

Twenty-seven years ago, my first job out of school was a child protective job; and my first day, my first training case, I was taken by an officer of this agency to an apartment in central Harlem. He knocked on the door. The door was opened by a woman against whom a complaint for child abuse had been brought.

She came to the door. In her arms she held a 2-year-old child who was bruised. However, her own face was so bruised and beaten that she could barely see us. I spent the next 2 hours in her apartment watching as she was interrogated by this officer about the complaint, about the alleged abuse of the child.

It was clear from her testimony, from all the evidence we were hearing, that she was not the abuser of the child. Her husband was. Not once were her injuries even acknowledged by this officer. Not one question was asked. This was in 1967.

I left angry and frustrated and ashamed. Angry because of an injustice that I had seen done to her, angry at the abuse she was receiving, angry at the fact that it was not even acknowledged, frustrated because I wasn't sure I would have known how to do the job differently, ashamed because I had participated in what I clearly perceived as a new injury and injustice to her.

As I see new people brought into the circle of understanding of the domestic abuse of women, like Dr. McAfee's really heroic work the last few years, I see the same starting from scratch. How would I do it differently? How do I understand this?

So it's thrilling. It's thrilling when people are brought into this circle. But we start from square one again with each person we teach. And we have to begin to do it systematically and with the appropriate resources. Thank you, Senator.

[The prepared statement of Mr. McLaughlin follows:]

TESTIMONY BY BOB MCLAUGHLIN, CHAIR, HEALTH CARE RESPONSE COMMITTEE, MAINE COMMISSION ON DOMESTIC ABUSE

Thank you, Senator Cohen, for holding this hearing on family violence in Maine. And thank you for inviting me to be here today to provide information on this subject to you and to this Committee.

Personally I am keenly concerned about all aspects of family violence. As a member of the Maine Commission on Domestic Abuse, as I will explain in a moment, I am primarily concerned not only with violence against women but with the much larger spectrum of damaging behaviors toward women we refer to when we use the term abuse. And as Chair of the Health Care Response Committee of the Commission, I am especially concerned with what, in your letter, you refer to as the public health implications of abuse against women.

It is because of my public health concerns that I have decided to respond to your request for my testimony with a proposal. I propose that you and this, or another appropriate Senate Committee, the United States Senate, and the Congress of the

United States create a major national public health initiative to prevent and reduce the domestic abuse of women in Maine and in America.

In a moment, I will describe my proposal and present my arguments for it.

Before I do this I need to do three things: Explain what the Maine Commission on Domestic Abuse is. Explain what I mean by some of the words I will use. And, in response to your letter of invitation, describe for you what I believe is the nature and extent and the factors which contribute to the domestic abuse which I and the Commission are responsible for addressing.

The Maine Commission on Domestic Abuse was established in 1990 by the Maine Legislature, in MRSA Title 19, Chapter 14, § 770–B, to "advise and assist the executive, legislative and judicial branches of State Government on issues related to domestic abuse", including "recommendations on legislative and policy actions". We are an unfunded Commission, chaired by the Commissioner of the Maine Department of Public Safety, a cabinet level official, which meets monthly to support and coordinate individual and collective initiatives and responses by its members in support of our statutory mandate. As members we serve voluntarily, without compensation, except in cases where membership is supported as a job responsibility by a member's employer. We have no staff. From the time the Commission was created until May of this year we were led by Public Safety Commissioner John Atwood whose deep commitment and dedication to the work of the Commission will be difficult for any Governor to replace. Our acting President is Lois Reckitt of Portland, Director of the Family Crisis Shelter, the abused women's shelter and advocacy program for Cumberland and Sagadahock Counties.

Next, as a preface to my proposal to you and to this Committee for a public health response to abuse, Senator Cohen, I want to explain what I mean by some of the words I will use and explain the nature and extent of domestic abuse and the major factors contributing to it. Because I believe that its nature, its extent and the factors which contribute to it provide the major arguments in favor of my proposal.

As a member of the Maine Commission on Domestic Abuse my testimony is about woman abuse. Although terms like domestic abuse and family violence are legitimate generalized terms for any abuse which occurs in the setting of families, households or intimate relationships, they are often used as euphemisms for the domestic abuse of women. And the domestic abuse of women is what the Maine Commission on Domestic Abuse is charged with confronting. That was the understanding of the Judiciary Committee of the Maine Legislature when it took the initiative to create the Commission. The day woman abuse was first named for me I became aware of our unwillingness in America to call woman abuse by its name. This unwillingness is the first obstacle we must remove in order to confront it. To call woman abuse by the name of woman, therefore, is I believe, the first political act we must take in order to prevent, reduce or eliminate what is the number one public health risk to adult American women, and the leading cause of injury to American women between the ages of 15 and 45.

Here is my view of the nature and extent of woman abuse.

Woman abuse is inflicted upon women by an abuse regime which has three parts.

The first part of the abuse regime is that huge percentages of women among us are chronically and systematically abused by males with whom they are intimate. The tactics of abuse they experience from these males constitute a broad spectrum of behaviors. We have learned from our national experience that these tactics are expressions of an assumption of male right to control women's status and behavior. These tactics take the form of actions which limit and control women's behavior, emotional and psychological state, and achievement. In short, the intent and the effect of abuse tactics are to limit or destroy a woman's life, liberty and pursuit of happiness. These tactics include a huge spectrum of hundreds of behaviors ranging from verbal statements to murder.

The second part of the abuse regime is that women who are not directly abused are born, grow up and live out their lives in our communities in the presence of women who are directly abused. They live at high level risk of being physically, sexually, emotionally and psychologically assaulted themselves by individual males in their environment. Finally, virtually all women experience being controlled by the beliefs, the words and the deeds of men in their environment who, whether consciously or unconsciously, maintain powerful and long-standing historical institutions and cultural traditions which act collectively in a way that controls and limits what women can do and who they can be, simply because they are women.

These first two parts of the abuse regime result in vast amounts of primary physical, emotional and psychological injury and damage to American women. This ranges from death and permanent physical or psychological disability due to acute physical and psychological trauma, to failures of aspiration, achievement and fulfill-

ment in school, professional and personal life, including lives lived out earning fractions of their male counterparts for the same value or work.

The third part of the abuse is that the rest of us—primarily male—as individuals, members of communities and citizens of this nation, live in a state of emotional and intellectual denial of this fundamental condition of women's lives. Our denial and its effects results in uncalculated amounts of, additional, secondary, physical, emotional and psychological injury and damage to American women. This is because it is our denial, our failure to acknowledge and respond to the condition of women, to woman abuse and to women who are abused, which operates as the crucial social support for the tactics of abuse and their perpetrators. Without our individual and collective inattention and inaction the interlocking personal and social regime of woman abuse could not operate. To paraphrase William Burke: All that is necessary for the forces of woman abuse to win in the world is for enough good men to do nothing. To do nothing to make the status of women equal to the status of men in our personal beliefs and values, our personal behavior, and in our collective behavior as dominant authors of the status of women in the identity and operation of our communities, our society and our culture.

Here is my proposal.

First, I am recommending authorization and appropriation of at least $50,000,000 to be made available to the states to begin the task of retraining existing health care providers in the clinical skills required to identify and effectively respond to the 25 to 35% of unidentified women health care patients in America who are being abused in their domestic relationships. These funds should be used to provide systematic and comprehensive retraining of existing health care providers to identify and effectively respond to abused women and their children in all health care settings in ways that will prevent and reduce the abuse which injures and damages them at such high rates every year. To be effective, this retraining program must be based on adult learning principles. It must extend over a two to three year period during which the skills of identification and effective response to women abuse are learned, evaluated, consolidated and supported. It should include an evaluation and research component for each state which measures the increase in effective health care response and reports it in ways which validates and supports the changes which are expected in the behavior of health care providers, and teaches all of us more about how to train and respond more effectively.

Second, I am recommending that no further time should be wasted in limiting federal funding of public health responses to domestic abuse of women to small demonstration programs over three year funding cycles. I am extremely grateful for the two tiny federal demonstration programs of public health responses to women abuse which are about to begin, one sponsored by the Centers for Disease Control, the other by the Bureau of Maternal and Child Health. These represent the first federal public health initiative on women abuse. And I recognize and deeply appreciate the leadership represented by these programs. But it is inadequate. As a nation, and as a health care community, we are way past the need to demonstrate the need for a public health response to domestic abuse of women. We have more than enough information and national experience to warrant full funding for a comprehensive national public health initiative to reduce and prevent domestic abuse by providing the basic requirement of such an initiative: health care providers who know how to identify abused women who come to them for health care services and who know how to respond effectively to help prevent, reduce or stop further abuse.

(Both John LaCasse, President of Medical Care Development Inc. in Augusta, who submitted a proposal for the Centers for Disease Control program, and Bonnie Post, Executive Director of the Maine Ambulatory Care Coalition, the coalition of all twenty-six of Maine's rural health centers, who submitted a proposal for the Bureau of Maternal and Child Health program, support these recommendations on federal funding.)

Third, I am recommending that federal legislation create the mandates and incentives required to insure that all primary and secondary training programs for health care personnel provide comprehensive training in these clinical skills as a condition of program accreditation, and to insure that all states require competence in these clinical skills as a condition of licensure for all new health care providers.

Finally, I am recommending that significant new funding on both a state and national level be provided for shelter and advocacy programs for abused women: In order to help provide the training which health care providers require; In order to extend the services of shelter and advocacy programs to meet the current unmet needs of abused women and their children; And in order to extend their services to meet the dramatic demand which will be result when health care personnel become trained to identify and effectively respond to domestic abuse of women.

My argument for this proposal in this testimony is not detailed, exhaustive, or annotated. The short notice of this hearing made that impossible. My intent in this testimony and in response to your questions is only to provide you with enough information, together with the testimony of others at this hearing, to persuade you and the committee that such an initiative should be seriously considered. With appropriate time I can assure you there is more than enough evidence available in the national health care literature and the testimony of a growing state and national community of health care providers and researchers to make the case for my proposal exhaustive and overwhelming. I hope that this or another appropriate committee of the Senate will decide to assemble that evidence. If you do I will certainly be willing to help you.

I am urging a major public health initiative against the domestic abuse of women for eight major reasons. Each of these reasons have emerged from the state and national experience of abused women in health care services, the experience of those of us who work with the health care community on this problem in Maine and across the nation, and from the growing body of research on the health care response to abused women.

First, woman abuse is wrong. It is a crime against persons and it is a crime against the community. And, from an epidemiological point of view, its incidence and prevalence is so high, and the will of our collective and dominant community and social institutions to stop it remains so low, that it can reasonably be understood as a major sustained crime against gender which relies on the widespread public support provided by chronic social and community inaction to end it.

Second, millions of American women are known to be abused in their domestic relationships. Millions of these have been identified—enumerated in a variety of reporting and research programs. Moreover, these same programs of reporting and research provide evidence that millions more women, who remain unenumerated and unidentified, are known to be abused.

Third, these millions of American women suffer high levels of physical, emotional, psychological, and economic injury and damage. Incalculable in human terms, as losses of life, liberty and pursuits of happiness, this injury and damage has only begun to be calculated in economic terms.

Fourth, the millions of children of these abused women suffer high levels of physical, emotional, psychological, and economic injury and damage. This is injury and damage which no amount of work against children abuse will ever be able to reduce if it continues to be as separated and isolated from the work against women abuse as it has been allowed to become in America during the past century.

Fifth, research suggests that 25 to 35% of women patients who seek general medical services in ambulatory care settings are experiencing injury and damage from domestic abuse—perhaps ten to twenty times the number who seek specific domestic abuse services from the criminal justice system, the shelter and advocacy programs for abused women, or any other social service institution in Maine or anywhere else in America.

Sixth, research has also demonstrated that only between two and five percent of the abused women who seek general medical services in ambulatory care settings are even identified as experiencing abuse. And, of the women who are identified, few receive a response which is likely to prevent or reduce the abuse they are experiencing. America's health care providers do not know how to identify or effectively respond to abused women because they have received either no training or inadequate training in these skills in both their primary and secondary medical training programs.

Seventh, the failure by health care providers to identify abuse as the cause of physical, emotional or psychological symptoms in abused women results in inappropriate or even punitive responses, which fail to prevent or end the abuse, may entrench women further in abusive situations, or even cause new injury and damage.

Eighth, the methods for effective identification, primary, secondary and tertiary response to abused women have been identified and developed in the nearly 1200 shelter and advocacy programs for abused women created across American between 1976 and 1984. And the expertise in how to use them and how to teach them resides in the thousands of advocates who have staffed these programs for nearly twenty years. These methods are being consistently validated by the experience of the few health care providers who have just begun to use them. And they are now becoming available in well developed curricula which can be further developed for any health care training setting, from the remedial programs for existing health care providers which I am proposing as an immediate national initiative, to the primary and secondary training programs which would be required to provide such training to new health care providers.

Finally, because of the huge number of abused women who seek health care services, health care providers in health care settings, collaborating with abused women's advocacy programs the civil and criminal justice systems, can provide Maine and the nation with the most effective way to identify and effectively respond to the greatest number of abused women and their children, at the least cost and with the greatest use of existing institutions and resources.

What would be the result, in Maine, if this Committee, the United States Senate, and the Congress were to accept my proposal and create the national resource of training health care providers and adequately funded abused women's programs?

To illustrate the result, I will extrapolate what data and research we have from other parts of the nation to Maine and to the thousands of women annually who seek medical care at Maine's major ambulatory care providers, the forty hospital emergency rooms and the twenty-nine rural health centers.

This extrapolation is necessary because we do not yet have comparable data and research for Maine. But what we do have, including the preliminary data from Maine's rural health centers, presented here by my fellow panelist Dr. Eric Brown, suggest that the numbers of abused women in Maine who seek health care but are neither identified or responded to effectively are comparable. By extrapolating this research and data I will suggest how we are failing abused women in health care settings now and how this could change if this state and nation created the resources I am proposing.

Research completed in the United States during the past decade has discovered the following facts: Domestic abuse is the single largest cause of injury to American women. It causes one in four suicide attempts and half of all rapes of women over thirty. Hospital studies using large samples found that 22% to 35% of women visiting hospital emergency departments present symptoms resulting from the physical, emotional and psychological tactics of both acute and chronic abuse and symptoms resulting from the physical, emotional and psychological tactics of survival which abused women must adopt, chronically, to withstand chronic abuse regimes. But these same studies demonstrated that only between two and five percent of these presentations are identified as resulting from abuse.

To my knowledge no published studies of this kind have been done in Maine. But I have examined the results of two consecutive chart reviews, one year apart, in the Emergency Services department at a major medical center in Maine which show rates of identification around 5% in samples of 100 charts, suggesting that the published hospital studies may be applicable here.

If we apply these findings to Maine, and conservatively assume that 50% of Maine's hospital emergency service visits are by women, this analysis suggests that of the total of 615,000 emergency department visits to Maine's thirty-nine community hospitals in 1992 reported by the Maine Hospital Association, between 67,000 and 107,000 of them were by women secondary to abuse and that at most, only between 2000 and 5300 were identified as such.

According to the Maine Ambulatory Care Coalition, Maine's 29 rural health centers had roughly 220,000 out-patient visits in the last year of record. If the experience of abused women in Maine's rural health centers during the last year of record is consistent with that reported in the hospital emergency services studies, we can estimate that between 24,000 and 38,000 of those visits were by women presenting symptoms resulting from abuse. And if identification rates were 2.5 to 5% we can assume that only between 500 and 1900 resulted in identification of abuse as a precipitating etiology.

Finally, even if the out-patient visit total number was to be cut in half by factoring in multiple visits by the same women, the potential number of missed identifications would still be very, very large.

We are certain that such low rates of identification and appropriate clinical response to presentations of cardiovascular risks in men, for example, or any of scores of other clinical presentations would never be tolerated in out-patient medical care settings. It is to the credit of the Maine Ambulatory Health Care Coalition members that they have actively begun to recognize that they must retrain their medical care providers and have begun to seek funding for a program which would do this.

Missed identifications of abused women are not benign. In one study of battered women who attempted suicide, for example, eighty-five percent of them had been seen in the hospital prior to the suicide attempt for at least one abuse injury without being identified as abused women and without receiving any preventative response from health care givers.

One of the two major epidemiological reviews of data on woman abuse describes the general record of medical response in the following way:

Descriptive studies frequently report inadequate professional care, including neglect and the treatment of abused women and secondary problems as "deliberate de-

viants". Despite their failure to identify abuse, physicians are more likely to refer battered women to emergency psychiatry (37% to 7%) and to label them as hysterics, neurotic, hypochondriacal, and as having psychosomatic disorders. [Three studies, in fact, found that 88% of all such labels appeared in the records of abused women!] Battered women are also more likely to be prescribed tranquilizers or pain medication and eventually to be institutionalized at the state mental hospital. At advanced stages of abuse, clinicians interpret secondary consequences, such as female alcoholism, as the *cause* of the violence and intervene to stop these secondary problems with a variety of punitive and/or family maintenance strategies that entrap women in violent relationships. [emphasis added]. Battered women who attempt suicide are more likely than non-battered attempters to receive no follow-up. Finally, battered mothers of abused children are more likely to have their children placed in foster care than non-battered mothers.

Indeed, the effects of this failure to identify and treat appropriately (a response to abused women which is also characteristic of most other social services) has now been included by epidemiologists as an integral element in what is being called the battered women syndrome.

Although battering and abuse are sometimes used interchangeably, battering can be used epidmiologically to refer to a syndrome attended upon spouse abuse and characterized by a history of injury (often including sexual assault), general medical complaints, psychosocial problems, and unsuccessful help seeking from unresponsive care givers. In reviews of hospitals records, [researchers] have identified a battering syndrome among abused women in which a history of trauma is accompanied by a disproportionate risk of rape, miscarriages, and abortion, alcohol and drug abuse, attempted suicide, child abuse, mental illness [which are sequelae, following the historical onset of abuse]. Paralleling this multi-problem profile is a history of help seeking marked by neglect and by inappropriate and punitive responses * * * the dual trauma of personal assault and institutional victimization lead to an increasing sense of isolation, entrapment, self-destructive behaviors, and even homicidal rage.

In other words, failure to identify and treat appropriately not only permits the regime of injury to continue unchallenged, it produces so-called iatrogenic damage as well: behavior by medical caregivers which increases the physical, emotional and psychological injury of abuse.

This analysis suggests to us that raising the identification rate in Maine's hospitals and health centers to even 25% would result in between an estimated 17,000 and 27,000 hospital identifications and 6,000 to 10,000 health center identifications annually for a potential estimated total of between 23,000 and 37,000 increased identifications annually. Whether this is compared with the estimated 2,500 to 7,200 total identifications made now by hospitals and health centers in Maine or compared with the 4,500 criminal justice system identifications in Maine in 1993, and the 8,000 battered women's services system identifications in 1993, it would represent a dramatic increase in the number of identifications of adult victims of abuse in Maine.

Furthermore, if Maine's hospital and health center systems responded to these newly identified adult abused women with clinical personnel trained to offer the most effective available treatment response, the potential reductions in injury and damage to Maine women would be major.

With such a response by Maine's medical institutions in close collaboration with abused women's programs and the civil and criminal justice system, acute and preventive resources could potentially be brought to many times more women in Maine's hospital and health centers systems than are now being provided in all Maine's abused women's advocacy programs and the criminal justice system combined.

This would be true simply because, as all the available data demonstrates, ambulatory health care services are the places where adult abuse victims present with the physical and psychological injuries of abuse. And they present to these services in numbers far, far greater than their presentation to any other services, including abused women's services and justice services combined.

Finally, by implementing identification and response policies which increase coordination among health care, abused women's and justice service providers, a coordination shown to be a required element of the most effective medical response to adult victims of abuse, the quantity, quality and effectiveness of the total preventive community response available to abused women can be dramatically increased.

The result of this initiative would be a major decrease in the social supports of woman abuse in Maine. It would mean a major increase in the status of women in Maine's health care delivery system. It would mean a major positive impact on the epidemiology of woman abuse in Maine resulting in a dramatic increase in the public health of Maine women.

Before I described my proposal to this Committee, I gave you my description of the nature and extent of woman abuse in Maine and in America. The accuracy of this description is borne out in the stories of thousands upon thousands of American women over centuries, in the descriptive current and historical statistics which tell about who we are, what we do, how we do it, who benefits and who does not. And, tragically, it is being borne out in study after laborious study of the experience of women in America.

We need only listen to the testimony of the abused women on our first panel of witnesses this morning, and we need to look no further than the American Association of University Women's 1992 report: *How Schools Shortchange Girls,* to be confronted by the comprehensive reach of the abuse regime into the lives of American women.

Our hopes lies in the fact that American women continue to sustain an unbroken tradition of active resistance against this regime. It is a tradition which reaches far back into the life of the early republic. You can hear its voice in the letters of Abigail Adams, the wife of our second President, through the record women's temperance movement—the first abused women's movement in America—and in the papers of Susan B. Anthony and Elizabeth Cady Stanton, which have, at last, been published. You can hear it in the deluge of women's history which has been written for the first time in the past quarter century. You can hear it in every single case, however shall, throughout the homes and workplaces and public institutions across the nation when women stand their ground against acts and systems of discrimination against them as women. You can hear it in the testimony from the courageous women who spoke on the first panel this morning.

I assert that the existence of this tradition of resistance against the abuse regime is of great epidemiological significance for the public health of American women. After all, it is the voices of women which have given us the language since 1975 to name their battering and abuse. It is our response to the sustained voices of women resisting abuse which have finally brought us all there today.

In the early 1980's the Centers For Disease Control made the first exploratory attempt to find out in the classic principles of epidemiology and the American Public Health movement in America could be applied to domestic abuse in America. In epidemiological analysis the goal is to identify two types of risk "markers", factors that create the risk for the affliction you are analysing: social risk markers and individual risk markers. I think this Committee should know that the researcher who did this work for the Centers For Disease Control reported two findings which are stunning.

First, he reported that the social risk markers in the epidemiology of women abuse in America are the following: The status of women in the society. The level of abuse of women in the society. The general level of violence in the society. This means that the lower the first risk marker and the higher the second and third risk marker the greater the chance for any individual women to be abused. This means that anything we do to raise the status of women in our society makes all women safer. It means that anything we do to lower the status of women in our society puts all women in greater danger. It means that anything we can do to raise women's status and fail to do has a direct result in injury, damage or death for which we must share responsibility.

Second, he reported that there is only one risk marker for women. Only a single factor that creates her risk of abuse. That factor is that she is a woman.

Thank you, again, Senator Cohen, for the opportunity to testify before this Committee. I will be happy to answer any questions that you have for me.

Senator COHEN. Thank you very much, Mr. McLaughlin. I have a number of questions, if I could, I would like to address to the panel, but in view of the time I will not. As a matter of fact, the testimony was so comprehensive that you practically answered all the questions I was going to pose to you.

But I would like to focus on what Dr. Brown has said in the sense of it's not enough just to simply focus upon the medical profession, be it nurse practitioners or physicians or nurse's aides or whomever, because that will not solve the problem. It will make you an intervenor in a, "domestic situation without much relief or protection if the other segments of the entire system don't respond accordingly."

We talked about an attitude change on the part of physicians. Dr. Brown mentioned this. Dr. McAfee also talked about this. But it has to be an attitudinal change in our society in its totality.

Whether we use the word illness or not, whether it's inappropriate and dangerous to do so, I think it would be safe to say there is a sickness in our society today when it comes to violence. We see it in every facet of our society.

Daniel Patrick Moynihan wrote an article last year. It appeared in one of the magazines, I can't recall which, but he called it, "Defining Deviancy Down." In that article he pointed out that, at the time, the Saint Valentine's Day massacre made worldwide news.

I think there were four individuals who were cut down by gunfire by three others or vice-versa. Regardless, it made world news. It's still cited as one of the most outstanding events of the year. I think it was 1929, or 1927.

That act today wouldn't make the front pages of most newspapers. Go to Washington, D.C., and you're likely to turn to the metro section to find something comparable. It's not big news any longer. And so we have defined deviant behavior down to a level where our sensitivities have become completely numbed.

As one judge in New York said, it's the equivalent of a combat soldier who has been in combat for extended periods of time. They become so numb they can sit on the bodies of the fallen, friend and foe alike, and eat their rations. That's the level of insensitivity that we are falling to in our society.

Something caught my eye in the Bangor Daily News this morning, something with a picture of Oprah Winfrey. The thrust of the article was that the daily discussion of what I would call perversion—maybe I'm being a little bit old-fashioned about this, but the daily discussion of "I was a teenage transvestite who had a relationship with my mother's stepfather" or whatever it happens to be, day after day after day, and every program, not just hers, but Phil Donahue or Geraldo or, you name it, the day in and day out discussion of this and talk about it has made people think, well, it's kind of normal. It happens all the time.

And so instead of these behaviors being stigmatized, or something to be prevented, or discouraged well, everybody seems to be doing it. We have less of a sense of moral outrage at what is taking place.

I recently attended a hearing at the request of Senator Carol Moseley-Braun about gangsta rap. I didn't know a darn thing about gangsta rap. I had never heard it before that day.

I agreed to sit in even though I had a busy schedule that day. It was one of the most fascinating hearings I have ever attended with literally hundreds of people in the audience and at least a dozen cameras who were capturing every word that was spoken about gangsta rap.

The lyrics of some of these rap songs are so vile and so violent that it would cause us to be completely embarrassed by them. They urge males to treat women as little more than instruments of their pleasure to the point where they can rip open their anatomy and if they don't like that, cut their throats.

And this is being pumped into the ears of very young and, I suspect, vulnerable young people in this country, particularly in urban areas.

I asked one of the young producers of a—I think it was Rap Magazine. I handed him a copy. I said, "Have you ever read the lyrics of this particular song?" And he said no. I said, "Well, here they are. Would you mind repeating them for us, for the committee this morning?"

And, of course, he became flustered. His face turned red. He said, "I can't. I can't do this."

I said, "Why not?" He said, "Well, children might be watching."

I said, "Children? This is C–Span time. It's 9 or 10 o'clock in the morning. You think children are home watching C–Span today?"

He said, "I can't do it." He could not bring himself to repeat the lyrics of this particular song that were so bad because he was embarrassed. This is material being read to adults and he knew it was shocking.

And yet this is precisely what's going into the ears of our children day after day after day, and people who are producing it are going to the bank. They're making billions.

So there is little that can be done with just educating the health care providers if we don't change the attitude of everyone throughout our society, and that's just one example of it.

Ironically enough, this recent case that you talked about, Dr. McAfee, that will obviously garner a great deal of attention throughout much of the world in the coming weeks and months, will perhaps do more to highlight the problem than any of our talking about it at hearings such as this. And now that the great and the famous and the celebrated will be revealed as having engaged in conduct that is all too prevalent, we may now finally start to see below the tip of the iceberg.

And it won't be confined to cases in low income housing projects but people who live in Beverly Hills and some of the grander places all across this country.

It is a subject matter that is shocking in its proportions, and we simply haven't talked about it. We don't want to know much about it.

And another component of the court system, Dr. Brown, is that—I think it was Sharon who talked about it—is that when you show up for a court appearance, the judge may end up continuing the case so you have shot another day of a thousand dollar overhead to begin with, to be rescheduled for a day in which there may be another continuance granted.

So there's a whole system that seems geared to discouraging, not knowingly, but unwittingly discouraging dealing with this in any kind of systematic and professional way.

Mr. MCLAUGHLIN. If I might, Senator, it's that issue about desensitization I was concerned about.

In the Bangor Daily News front page this morning, there is the first of probably many similar articles you will read. There will be those who will be attempting to define O.J. Simpson's behavior as one form of illness or another.

Desensitization is the effect of such attempts to define his abrasive behavior toward his wife as an illness. The effect of such at-

tempt is purposeful or not, is to relieve him of moral responsibility and us of moral outrage.

I have counseled many batterers. One of the things you do is to break down that attempt at denial of responsibility. You do it by tracking the behavior which you have on the police record and demonstrating to that person that he was making choices at every step of the way.

So you will—the article this morning in the Bangor Daily News reveals how psychologists and psychiatrists especially need the kind of training I'm proposing, and they are included in the health care provider. They are as unprepared as any physician to address this behavior.

Senator COHEN. Well, I don't disagree with you. As a matter of fact, I think we are laying the foundation for a sort of Menendez brothers defense. We can take another whole day to talk about whether or not what has happened in one's past experience can be offered or should be offered as justification for your own choice in what you engage in.

But I think the message has to go out and very loudly: "No one is allowed to strike, to harm, or to abuse another either physically or emotionally; and we have got to really calibrate our health care system, judicial system, social service system to deal with that if we are going to call ourselves a civilized Nation.

I thank all of you for coming in.

Dr. McAfee, I appreciate your coming in for the AMA. We look forward to seeing you later in the year.

Dr. Brown, Dr. Fishwick, Mr. McLaughlin, thank you very much.

[Recess.]

Senator COHEN. Let me welcome our fourth and final panel this morning. Our first panelist is Francine Stark, the Community Response Coordinator for Spruce Run Association that serves hundreds of abused women and children of Penobscot County.

Ms. Stark has been of enormous assistance to me and my staff in addressing issues of violence against women. We are very fortunate to have you with us today.

We are also pleased to have with us this morning Peggy Dumond, Deputy Director of the Eastern Area Agency on Aging. Ms. Dumond will address how elderly persons can be the victims of abuse and what services the communities can provide to help abused victims.

Also joining us is Lieutenant Don Winslow, Deputy Chief and 15-year veteran of Bangor Police Department. Lieutenant Winslow has a strong commitment to combating family violence and is actively involved in community efforts to address the problem. We appreciate your taking time to join us this morning.

And finally, Alice Clifford, Assistant District Attorney for Penobscot County, with extensive experience in prosecuting family violence cases will be testifying this morning.

Ms. Clifford was the chairperson of the committee that wrote the domestic abuse prosecution model policy for Maine, and she is on the steering committee of Spruce Run, a member of the Maine Commission on Domestic Abuse and trains police officers on domestic violence. Thank you for coming.

Before we begin, in view of the hour, I'd ask you to summarize as best you could your statements. The full statement will be part of the record. I'd like to give each of you an opportunity to summarize if you could so I can take a plane back to Washington.

Let's start with you, Ms. Stark.

STATEMENT OF FRANCINE STARK, COMMUNITY RESPONSE COORDINATOR, SPRUCE RUN ASSOCIATION

Ms. STARK. It's difficult to summarize at this late hour, especially being inspired by all the people that have spoken before. I would want to take the first 10 minutes to expand on all the things that were said.

I'd like to emphasize first of all that the Spruce Run Association, like most domestic violence programs, is primarily a crisis hotline, and we overemphasize the issue of shelter. We serve over 1,000 women, nearly 2,000 women every year on our hotline, but we shelter less than 100 families each year.

The hotline is a critical piece of our fabric and so since we're having language conversations today, I thought I'd bring that up.

I think that the folks who spoke earlier have emphasized for us the relentless nature of abuse, that abusers continue their activity well after a woman has left. And although people are constantly talking about why do women stay, the fact of the matter is that women are leaving all the time, and that the abuse simply increases and changes character after they have left. The role that we are all talking about having is in making it possible for women to leave and stay safe.

So I will try to summarize the pieces of this that seem important to me to mention in spite of our short time. One of the things that's often brought up is the issue of guns and violence. I'd like to point out that 97.5 percent of the domestic assaults in Maine involve personal weapons.

In fact those things that assault women and children in their homes are primarily hands, fists, and feet, and that women are often threatened with guns but in fact most of their injuries are created just by this man's determination and personal strength.

So we can't overemphasize guns as a cause of violence; it is just one more means of making it more lethal.

Senator COHEN. I was struck by the fact that Roberta mentioned that her friend was 250 pounds but found it necessary to threaten her with a gun. But that makes your point.

Ms. STARK. Absolutely. I think what is important for us today is the hopeful news that domestic violence is being widely recognized as a serious problem. And, in large part due to the efforts of the battered women's movement, the criminal justice system has made substantial progress in treating violence against women as a crime, even when the perpetrator is married to the victim.

Protection from abuse and protection from harassment orders are available and have provided relief for thousands of women and children. Unfortunately we only hear about those cases in which those protective orders fail.

Thousands of protective orders are issued all the time and provide a certain level of protection for women, particularly as regards

their rights to have their children and not have them kidnapped by their abusers.

As we talk about gangsta rap being piped into the ears of our children, the language used by abusers is not so terribly different and the threats made against their wives' bodies and the things that will be done to the children and the women in the event that the abuse comes out is very much like gangsta rap, and it's being piped into these children sometimes when they're court ordered to listen to it, because they have to be with this man, because he is their father.

Unfortunately, at the same time that we have this increased awareness of domestic violence, there are hundreds and thousands of women coming forward to us, seeking assistance.

We live in a time when there are diminishing resources in all aspects of our community that are making it difficult for women to stay free, to say nothing about our programs which are working with the same level of staffing that we had in 1986, but you can well imagine the increase in demand for our services over that time.

Money is a major issue. But I'd like people to focus as well on the lack of affordable housing, jobs, child care, transportation, legal services, along with reductions in income assistance, all of which are very important to women being able to be free.

Our underfunded court system has such a backlog that it is usually months before an abuser goes to trial for assault, all of which time he is free to continue to harass and torment her, particularly if he has visitation rights with the children.

Even after trial, the most common sentence for domestic assault is 30 days suspended plus some period of probation. Lack of jail space is sometimes cited as the reason for this, but it also reflects a lack of willingness on the part of judges to put men in jail for crimes against their wives.

We often hear that our geography, lack of employment opportunities, layoffs at the local mill, substance abuse, or cabin fever cause domestic violence in Maine. It's important to keep in mind that both men and women experience these stresses, but it is the women in our State who are being placed in fear for their lives and are demanding our help in stopping the violence.

Men are commiting 95 percent of the reported domestic assaults. Domestic violence stems from the belief that men have the right to be the one in charge of their homes and that violence is sometimes an acceptable means of ending conflict and asserting power.

The men who believe this use violence as coercive control whether they have a job or not, regardless of the weather, and in any geographic location.

Women who are trying to escape violence are sometimes thwarted by their geographic isolation which limits their access to resources. But I think it's important that we look at these economic and environmental factors; rather than as causing abuse and providing justification and excuses for abusers, as the barriers to women leaving violent homes that they are.

I would like to emphasize the importance of our community working together. That has been brought up already. But I want

to be sure to say that not all children who grow up in violent homes are violent when they are adults.

We need to look at all the other adults in their lives and give them important training around this issue—Headstart and schools and all things that interact with children.

Right now there's a lot of talk about welfare reform. Because they come from all walks of life, not all abused women are poor. Not all abused women would use public assistance.

It would be interesting to see an actual study done of how many women went on AFDC after they left an abusive partner. Before we try to limit welfare assistance to 2 years, we are not taking into account all the stories that we have heard today.

The fact is that it takes years to be free from an abuser, and when you're in court all the time and your kids need counseling and they need stability and they need mom, she should not be taking herself a hundred hours a week away from her children in order to go to school, have a job and be away from them so that she's not on welfare.

Would we rather have her raising her children and trying to stop this kind of violence, or would we think that 2 years' limit is the more important goal? I think we need to look very closely at this in our welfare reform discussion.

We also need to be willing to say that there are men who should not have access to their children no matter what, even if their violence was only directed at that child's mom.

I was struck yesterday by O.J. Simpson's sadness at spending Father's Day away from his children. I would hope that everyone recognizes that he had taken the children's mother away from them forever and I think our sympathy should be with his children. That's all I will say, Senator.

[The prepared statement of Ms. Stark follows:]

June 13, 1994
Testimony for the Senate Special Committee on Aging
July 20, 1994 field hearing, Bangor, Maine
Provided by Francine Garland Stark, Community Response/Education Coordinator, Spruce Run Association, Bangor, Maine

I have worked on a hotline for victims of domestic violence for nine years. During that time, I have spoken with hundreds of women who have been abused by their male partners. I have talked with hundreds of women in shelters, who have been abused by their male partners. I have learned that women who experience violence and abuse in their homes want the violence to end. Women want to have peaceful lives, and they want their abusers to stop being abusive, to be the loving companions and fathers they believe them capable of becoming. Abusers, however, are relentless in their determination to maintain control over their partners' lives and believe themselves to be justified in using any means necessary to achieve that goal.

Abuse is frightening and humiliating. I have spoken with women who have been raped, stabbed, shot, choked, punched, slapped, thrown across the room, pushed down the stairs, and kicked repeatedly. Women describe being unable to use the telephone for fear that he will think that she is telling someone about what is happening in their home, being unable to keep a job, because he will not cooperate with childcare or let her use the car, being unable to keep friends, because he constantly accuses her of cheating on him, being threatened that he will kill her if she leaves, having him threaten to kill himself if she leaves. Abuse is a trap from which women struggle to escape. Women do not stay in abusive homes because they like it. Women are constantly resisting the abuse in order to survive and leave abusive men when it is clear that the dangers in staying outweigh the dangers of leaving.

Research by Dr. Evan Stark and Dr. Anne Flitcraft shows us that three to four million American women are battered each year by their husbands or partners. Their research suggests that wife-beating results in more injuries that require medical treatment than rape, auto accidents, and muggings combined. According to the Maine Department of Public Safety, in 1992 more than 38% of the reported assaults were "domestic", occurring between household or family members. 97.5% of those assaults involved personal weapons (hands, fists, feet). 60% of the homicides in Maine were related to domestic violence that year. In 1993, over 8,000 individuals contacted domestic violence projects in Maine for crisis services: hotline, shelter, support group.

The good news is that domestic violence is widely recognized as a serious problem. In large part due to the efforts of the battered women's movement, the criminal justice system has made substantial progress in treating violence against women as a crime, even when the perpetrator is married to the victim. Protection from Abuse and Protection from Harassment Orders are available and have provided relief for thousands of women and children. Some District Attorney's offices have victim witness advocates who provide support to women so that they can more safely and confidently testify against their abusers. Police officers in Maine today are very likely to arrest when there is probable cause that an assault has occurred, a dramatic change in response which has occurred in slightly more than a decade.

Unfortunately, at the same time that awareness of domestic violence has been on the rise and many more women are coming forward seeking assistance, resources to help them have been diminishing. Lack of affordable housing, jobs, childcare, transportation, legal services, along with reductions in income assistance are barriers to women trying to make the transition to a violence free life.

Our underfunded court system has such a backlog that it is usually months before an abuser goes to trial for assault, all of which time he is free to continue to harass and torment her, particularly if he has visitation rights with the children. Even after trial, the most common sentence for domestic assault is 30 days suspended plus some period of probation. Lack of jail space is sometimes cited as the reason for this, but it also reflects a lack of willingness on the part of judges to put men in jail for crimes against their wives.

We often hear that our geography, lack of employment opportunities, layoffs at the local mill, substance abuse, or cabin fever cause domestic violence in Maine. It is important to keep in mind that both men and women experience these stresses, but it is the women in our state who are being placed in fear for their lives and are demanding our help in stopping the violence. Men are committing 95% of the reported domestic assaults. Domestic violence stems from the belief that men have the right to be the one in charge of their homes and that violence is sometimes an acceptable means of ending a conflict. The men who believe this use violence and coercive control whether the have a job or not, regardless of the weather, and in any geographic location.

Women who are trying to escape violence are sometimes thwarted by their geographic isolation, which limits their access to resources. Lack of employment opportunities and lack of

substance abuse treatment in which they can stay with their children similarly block many women's attempts to get free from abuse. Rather than thinking about these economic and environmental factors as causing abuse, providing justification and excuses for abusers, they should be seen as barriers to women leaving violent homes.

Prevention in the context of domestic violence should be viewed on at least three levels:

In order to prevent people from being assaulted, we need to prevent children from learning that violence is an acceptable means of ending conflict or asserting power.

We need to prevent victims of assault from being victims of additional assaults and/or homicide.

We must hold abusers accountable for their violence.

Health care providers can play a helpful role in preventing violence. While the emergency room plays an important part in repairing the damage created in specific incidents of violence and collecting evidence for prosecution, the greatest opportunity for preventing further incidents lies with the primary care physicians, physicians assistants, nurse practitioners, midwives, nurses, and secretaries. Because domestic violence is a combination of coercive control and threatened or actual physical violence, women are in complex situations. During a routine exam, pre-natal, or diagnostic visit it is more likely that the health care provider will have the time to explore this woman's circumstances and offer assistance.

The most helpful thing a healthcare provider can do for an abused woman is to ask, "What can I do to be helpful to you?" Abuse is not like a typical medical problem. There is no prescription for it. Women must maintain control over what happens to them. Their confidentiality is extremely important. Women are justifiably scared that their abuser will find out that they have told someone about their experience, and the consequences may be severe. Healthcare providers can listen to women, validate their feelings, provide information about services and other resources in the area, and can collaborate with the woman in problem solving. It is a tremendous help to allow a woman to use a private telephone in the doctor's office to call a domestic violence hotline if she wants to do that.

The data available suggest that at least half of all women have at least one experience with abuse and that an even higher proportion of women visiting doctors' offices are in abusive

relationships. That being the case, having a individual in the office who is the domestic violence specialist would be a good idea. This person would get special training about the issues, attend conferences, participate in community networks, monitor the office's response to women, and keep up to date referral materials available for patients.

Working together, district attorneys, police departments, and domestic violence projects have made substantial improvements in the criminal justice system's response to violence against women. We are at a place now where the healthcare community is taking steps to become another part of this collaboration. We need to talk more with each other, participate on local task forces to develop and monitor efforts to create a safer environment for all of us. Training is a key part of change. Domestic violence projects provide unique expertise and a perspective which will help the healthcare community respond to abused women in a safe, supportive, and empowering way. The medical community brings additional resources, energy, and ideas. Health professionals can be instrumental in bringing issues into the open and encouraging change.

The role of the federal government in assisting communities to prevent and respond adequately to domestic violence lies primarily in financial support. Domestic violence projects are financially strapped. My own project is operating with the same number of paid staff that we had in 1986, but the demand for hotline crisis intervention has dramatically increased. Demand for our training programs is overwhelming. We need funds for both of these critical services. We cannot collaborate with community networks if we have no one available to attend the meetings and pursue new initiatives.

Funding for programs such as head start, pre-natal programs, healthy start, and similar efforts directed at children and their parents should include funding specifically for training about domestic violence to be provided by local domestic violence projects.

Housing grants should include requirements that in any new housing project there be transitional housing for women leaving abusive partners. Regulations should be in place so that when women notify their housing authority that they need to transfer to a different location, because they are not safe from an abuser, they will get an immediate transfer. At the present time, they are required to first abandon their current home and become homeless in order to get priority assistance.

Housing and welfare programs should address the fact that many abused women have no children or have adult children. They need assistance to survive. A woman should not have her choices limited to between staying with a violent man and becoming homeless.

In order to leave abuse, women often need assistance with legal services for civil matters -- protection orders, divorce, custody, and visitation issues. Maine's legal services are severely limited. The federal government can provide grants to increase numbers of legal clinics and services particularly in cases of abuse.

In campaigns for office, this issue should play a prominent role. We must raise awareness and create an atmosphere in which people find domestic violence to be as unacceptable as failing to pay social security taxes on domestic help.

Women from all walks of life have the experience of abuse. Not all require public assistance to get free, but many do. I would like to see a study done to determine the proportion of AFDC recipients who began receiving AFDC when they left an abusive partner. It is critical to recognize that leaving an abuser does not end the abuse. Women face years of struggle to establish a home, attend to the children's needs, testify in court, find legal assistance to get a divorce, enforce civil orders regarding custody and visitation, and respond to his attempts to win her back. She is likely juggling children, a job, school, and his ongoing intimidation and other coercive tactics. Recent proposals to arbitrarily limit welfare assistance to two years is punitive and fails to recognize the reality faced by millions of American women. Welfare reform which does not take domestic violence into account will increase the number of women unable to escape their life threatening circumstances and protect their children from the long-term consequences of a life under siege.

I would like to express my appreciation to Senator Cohen and the Committee for providing this opportunity to discuss these important issues.

Sincerely,

Francine Garland Stark

Francine Garland Stark

Spruce Run Association

Senator COHEN. Thank you very much.
Ms. Dumond.

STATEMENT OF PEGGY DUMOND, DEPUTY DIRECTOR, EASTERN AREA AGENCY ON AGING

Ms. DUMOND. I have been working within the social services field for over 20 years. Most of the experience that I have had has been in rural areas, and a good proportion of it has been with older people.

The typical or stereotypical picture that comes into your mind when you think about family violence is probably O.J. Simpson or a young woman with children battered by her partner or a parent abusing his or her child.

But family violence comes in many varieties, and I'd like to just talk a little bit of three examples of elderly people that I have worked with who were victims of family violence. I could relate dozens but I know you have a plane to catch.

I had a client who was very elderly, who was totally blind, and she suffered from severe, debilitating arthritis, who lived with her husband in a very remote area in Washington County.

He routinely left her alone all day. He didn't work but he just went for rides. And he used to move the furniture around before he left home in the morning so that really limited her mobility around the home.

We got her some frozen home delivered meals because he often didn't leave food around for her to eat. So he put them in the freezer which was in the cellar knowing that she couldn't negotiate the stairs.

This went on for a long time. Eventually she was hospitalized after he threw her down on her bed and broke her hip.

The Department of Human Services, Adult Protective Services, our agency and the local women's shelter came together, were able to offer her assistance while she was in the hospital and arranged housing for her in another area. But when her husband showed up at the hospital time after time after time, eventually she chose to go home with him, and she eventually died.

We had another lady who lived with her husband who was a pillar of the community. They were fairly affluent. He was very active in community affairs. He was handsome and charming. I thought he was a pretty nice guy at first until I visited with her when he wasn't home.

He would go out and about and when people said, "Where's your wife?" he just said, "Well, her health is poor and she doesn't get around much."

He wasn't physically violent as far as we were aware, but he was verbally and emotionally abusive. She was very frail, appeared depressed. He told her she was crazy a lot. He kept her isolated by refusing to transport her to doctors' appointments and by refusing home health care that was offered to her.

He was very suave about this so that it wasn't "No, I'm not willing to take my wife to the doctor." It was that, well, the car that she could get in and out of needed some minor repairs and he somehow never got around to getting it fixed. Oh, the truck worked fine but she couldn't get up into it, that sort of thing.

After working with her for several months—I just used to go back and forth. When I saw his truck pull out of the driveway, then I'd stop in and visit. A home health nurse and I were able to get her to the doctor. She got some much needed medical treatment including an antidepressant and things perked up.

This story has a happy ending because with the help of the medication no doubt and of support and encouragement and having conversations with people for a change, she got up the courage to leave him.

She is now living in elderly housing in the Bangor, greater Bangor area. Her health has improved quite a lot, and she's developed a new support network within the community.

Our agency recently worked with the Department of Human Services, Adult Protective Services, and the local police department in removing a very elderly lady who had a multitude of physical and mental problems from a situation in which she was locked in a dark room 24 hours a day by her son who had many emotional problems and was physically abusive.

She is now recuperating in a nursing home from malnutrition, a broken jaw, and a broken hip. She is much less confused now. This case was in the middle of Bangor.

Sometimes the abuser is a spouse. Sometimes it's an adult child. Sometimes it's just a long time friend. The victim may be a man or a woman, although it's usually a woman. The victim may be rich or poor. They may be in the middle of town. They may be out in the woods.

What they do have in common is that they're all dependent on their abuser, either physically or emotionally or financially or all three, that they're isolated from the community one way or another and that they lack other source of support.

I don't have any good answers as to what we're going to do about it. I just came here to tell you that it's extremely common and that those happy endings are very few.

I think that the medical and the law enforcement and the social services community are becoming increasingly aware and are struggling to do what can be done.

There's not enough resources. The same staffing level as 1986, that's awful. For our agency, one of the critical factors, something that's really frustrating, is that the issue of mental competence, like in the first situation, that of the blind lady, she was competent and we were powerless to protect her from a bad decision. We understand why she made it. It was the only person she knew. She had no family. She had no connections.

In the last situation, the lady locked in the dark room, APS was able to act on her behalf because she was obviously incompetent. And the second lady who left her abusive husband was very, very brave as she had to create a whole new life for herself.

It's real tough to leave everything that's familiar to you and to venture into the unknown. It's especially tough when you're old, you don't feel good and you're physically dependent on other people.

Education, awareness, all those good old buzz words are critical. We need more resources. Resources like APS and Child Protective,

resources such as Spruce Run need to be expanded greatly and supported and strengthened.

Senator COHEN. Thank you very much, Ms. Dumond.

Lieutenant Winslow.

STATEMENT OF LT. DON WINSLOW, BANGOR POLICE DEPARTMENT

Lieutenant WINSLOW. Thank you, Senator. As you indicated, I have been in public service for 18 years, first as an EMT; the last 15 years as a police officer. I could go on and on about the violence that I have seen associated with domestic violence, but I too will be very brief so you can catch your plane.

We live in a wonderful State, a beautiful community, predominantly rural, full of caring and hard-working people; but unfortunately we're not immune to the violent crime that is so often associated with larger metropolitan areas.

As your statistics reflect, we had 4,417 assaults, domestic violence assaults between household members here in the State of Maine in the last year. That is consistent with the 6-year trend of an increase in reports. My experience tells me that the actual number of incidents is incredibly higher.

Whenever we respond to a house for a domestic assault, and finally break that barrier and get the victim to talk to you, you realize that they may admit to five or six previous cases of abuse. If in fact they're admitting to five or six, you know it's in the dozens. And I think that number of 4,417 is ridiculously low compared to the actual number of incidents.

It is interesting that the statistics for violent crime in Maine is actually down over the past 2 years, but the reports of domestic violence situations are——

Senator COHEN. I think it's down except for rape is up, is it not?

Lieutenant WINSLOW. Rape is up, but in general murder, robbery are down. We had 174 domestic violence responses in 1993 in Bangor alone, and that is down from 220 the previous year. I'd like to think that it's because we're making progress in our community, but I think it's much too early to tell. That is not the norm.

Of those 174 domestic situations that we go into, a large percentage of them are repeat offenders. We go back and back and back to the same place over and over and over again, and it is so frustrating to the officers that have to respond because they feel they have been let down by the system because they go and jeopardize their life in some cases to make an apprehension, do exactly what they're supposed to do, and only to be sitting in the window doing their report and watch this guy get bailed out of jail and go back.

Senator COHEN. Or to have the complaint withdrawn.

Lieutenant WINSLOW. Exactly. When I was writing my testimony the other day, an officer walked by and I looked up and I said, "Give me a name of somebody that comes to mind when we talk about domestic violence." And he rattled off a name. So I pulled that name up in the computer. It's a name that was familiar to me because I see the daily reports that come across my desk every day.

This particular individual had 110 involvements with the Bangor Police Department in the last 5 years, sometimes as the complainant, most often as the suspect, but just—I'll start with June 1992.

He was arrested for a warrant; May 1992, assault; May 1992, bail violation; July 1992, disorderly conduct; July, assault, warrant arrest, assault, bail violation again, assault, disorderly conduct, violation of protection order. And the list goes on and on and on.

This same individual is still residing at the residence and the victim has gone back and continues to live there. It's just a repeated process that becomes very frustrating.

I think the State of Maine has really been one of the leaders in the Nation over the past few years. We have made a lot of progress. We have a mandatory arrest law in most domestic violence cases. I come from an era of law enforcement—I heard some testimony earlier about the sad case in 1967 when the officer wouldn't even ask, "What happened to you?"

We are far beyond that in our community, but even just 10 or 15 years ago, a normal response for the police was to separate the parties. "Well, we'll take him over to the brother's house" or "We'll take him somewhere else so he can sleep it off." And we weren't really attacking the source of the problem.

I think we have made some remarkable progress locally and in the State as far as law enforcement is concerned.

We now remain on the scene until we are comfortable that the victim knows what her options are, that she is entirely safe, an arrest has been made or the situation has been resolved.

But bear in mind, Senator, we are a reactive organization. By the time we get called, it's really too late. We would love to be more proactive. We just don't have the staff or the money to do so.

We do have, as mandated by law, a policy that requires us to follow a certain procedure when we respond to domestic violence situations; and also some better legislation has come to be where people that have been convicted of three domestic violence-related assaults in the State of Maine will now be prosecuted as a felon. And I think that's a real positive move.

I don't have the answers. If I did, I'd probably have an oval office somewhere, but I think as I see it some of the things that we can continue to do to improve our response to domestic violence: I would be supportive of additional mandatory training for law enforcement officers, but I also recognize the need that our government needs to provide us with the funding to provide that training.

We get mandated to do a lot of things and it puts the burden on the local community, and quite often the money is just not there. But this is a priority because it is taking up a majority of the officers' time and is certainly dangerous. It's a very dangerous situation for them to deal with so it's very important to us.

I think the concept of task forces are very positive. They enable people to communicate much better, and I think they give us a better way to efficiently handle some of these domestic situations.

We have a local task force. We worked closely with Spruce Run and the District Attorney's office over the last year to try to focus on what we could do better.

But, as mentioned before, staffing, we're operating under the same number, actually less people than we had 10 years ago. And Spruce Run and the District Attorney's office is in the same boat.

So task forces are wonderful, but we really need somebody that can be provided to us to do the coordination and go right in and do some of the legwork that is involved.

Tougher sentences, mandatory sentences I'm an advocate of, but I don't think that is necessarily just the answer. I think if you coop somebody up in jail for 20 years because he repeatedly beat his wife, that's 20 years that he's going to be getting mad.

And by the time he gets out, we're going to have some real problems. We have got to focus on some rehabilitation for some of these repeat offenders and hold them accountable for their actions, and show them that their behavior is inappropriate and try to work to get them rehabilitated so that they can safely go back into the community.

And I guess with that, I will thank you for considering my testimony.

[The prepared statement of Lieutenant Winslow follows:]

CITY OF Bangor MAINE

POLICE DEPARTMENT
Randy A. Harriman, Chief of Police

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BANGOR, MAINE 04401
TEL. 207/947-7384

June 15, 1994

Senator William S. Cohen
Special Committee on Aging
202 Harlow Street
Bangor, Maine 04401

Dear Senator Cohen:

Enclosed please find my testimony for the upcoming field hearing on family violence that will be held in Bangor on June 20, 1994.

I would like to thank you for the opportunity to participate in this process, and look forward to seeing you on Monday.

Sincerely,

Donald J. Winslow

Lt. Donald J. Winslow
Deputy Chief

DJW/sjr
enclosure

Mr. Chairman and members of the Senate Special Committee on Aging, on behalf of the Bangor Police Department and the citizens of this community, I would like to welcome you to the City of Bangor and the State of Maine. I would also like to thank you for taking the time to conduct this hearing and consider my testimony.

I come before you today as an eighteen year veteran of public service. For the past fifteen years I have devoted my career to the citizens of Bangor as a police officer, today holding the position of Deputy Chief. I suspect I was invited to testify today in part because of my commitment to a pro-active approach to law enforcement. After seeing hundreds of victims of family violence, maintaining a philosophy of prevention only makes sense.

The State of Maine is a predominately rural state, comprised of hard working, caring people. The State of Maine is not, however, immune to the violence usually associated with larger metropolitan areas. Last year alone there were 4,417 assaults reported involving household or family members in Maine; that's one reported incident every one hour fifty-eight minutes. While violent crime in Maine continues to decrease, this figure represents a six year trend of an increase in the incidents of domestic abuse being reported to police. My experience leads me to believe that the number of incidents of family violence that remains unreported is much higher.

In Bangor alone, our officers responded to 174 actual incidents of domestic assault in 1993. That's 174 times that a Bangor Police Officer responded to the aid of a victim, all too often bloodied and beaten, and always an emotional wreck. Imagine the frustration felt by the officer when he gets dispatched to the same address the next month, or the next week, or even the same day, to deal with a situation that is progressively getting worse. Family violence is a significant problem, and until society realizes that it is not acceptable, the problem will continue to grow.

The State of Maine has recognized the problem of family violence and has made some laudable progress toward combating it. Perhaps most significantly, legislation has been passed that makes an arrest mandatory in most domestic violence situations. Additionally, all police agencies are required to have a written policy for dealing with such incidents. Since these changes there has been a continuing trend of increasing reports of domestic violence. In 1988 there were slightly over 100 cases reported to the Penobscot District Attorney's Office, 42 of which were prosecuted. In 1993 there were 569 cases reported, 409 of which were prosecuted.

Spruce Run, the local domestic violence project, the Penobscot County District Attorney's Office, and the Bangor Police Department have joined forces in an effort to efficiently handle these reports and work toward a reduction of incidents. In February of this year a small grant was awarded to this group to help us meet our goals. Funding has made it possible to provide information containing guidance and support to the victims of domestic violence. Additionally, in April fifty-five Bangor Police Officers attended a four hour training course concerning issues of domestic violence.

In January of this year, we began taking a closer look at family violence in Bangor to see if there were any identifiable trends. During the first four months there were Seventy-three reported incidents. This statistic does not include reported incidents of suspected child abuse. As expected, victims are predominately, but not exclusively, female. Sixty-five victims were females, eight were males. Sixty-seven of the offenders were males, six were females. The relationship between the offender and victim is as follows:

* 29 live together
* 13 were married
* 11 are ex's (whether married at one time or not)
* 11 were otherwise related (parents, siblings, grandparents, etc.)
* 4 were dating
* 5 unknown

This group is currently attempting to develop a task force made up of people that play an important role in the cycle of violence in the home. Members of our legal system, medical institutions, social services, and the media will be invited to participate. I believe that task oriented groups such as these enhance communication between agencies and help to ensure a more efficient method of intervention. Experience tells me, however, that the failure of task forces are attributed to the lack of time, not the lack motivation, ability, or commitment of its members. Members are continually asked to do more with less within their own agency, particularly in the area of public and social services. What is needed is people whom can exclusively coordinate and do the leg work for these task forces.

Law enforcement officers are often the first people to intervene in domestic violence situations. Therefore, having officers equipped with the knowledge and resources to deal with these situations is imperative. I would support a recommendation that required all law enforcement officers to receive additional training, provided there was some assistance in funding to cover the cost. I believe that the Federal Government has a responsibility to provide such assistance when mandates create a financial burden on states and municipalities.

Additionally, we must make offenders more accountable for their actions. The State of Maine has made progress in this area. In 1992 the Maine Legislature passed a law requiring defendants found guilty of three domestic violence related crimes be prosecuted as felons. A nationwide mandate of similar policy along with mandatory minimum sentences which include rehabilitation should be encouraged. A prolonged jail sentence in itself may not prevent a reoccurrence, but if coupled with intense rehabilitation the likelihood is reduced.

You, Senators, are in a position to move society in a positive direction. Law enforcement, prosecutors and domestic violence projects are doing their part, let's focus on educating the public. By making funding more easily accessible to these agencies and rehabilitation efforts, you will help send a clear message that violence in the home is not acceptable.

Donald J. Winslow

Senator COHEN. Thank you, Lieutenant Winslow.
Ms. Clifford.

STATEMENT OF ALICE CLIFFORD, ASSISTANT DISTRICT ATTORNEY, PENOBSCOT COUNTY

Ms. CLIFFORD. Senator, I will try to make this short so you can catch your plane. If I can't do it, I know that Lieutenant Winslow has resources.

I'd like to join in thanking you for addressing this important problem and inviting the Penobscot County District Attorney's office to participate today.

As we've heard, this is an enormous problem. It's very far reaching. Our office alone prosecutes hundreds of domestic abuse cases every year, and I'd like to go into a couple of those cases. And I'll call the first abuser number one.

He first began with our office probably in 1987 when he assaulted his girlfriend and was prosecuted for that. His girlfriend did leave him. He then harassed the family. He was prosecuted for harassing by telephone and also violation of protection order.

He then went on to a second girlfriend.

Senator COHEN. How much time did he get for that?

Ms. CLIFFORD. He did not get any actual time on any of those. He was put on probation with suspended time with requirements of counseling and no contact, but in none of those cases did he serve any time.

He did go to a second girlfriend probably around 1988 to maybe 1992. During that time he was charged and prosecuted for a number of crimes including five different assaults, violation of protection order, terrorizing, criminal threatening, criminal trespass, criminal mischief, violation of condition of release, some of these occurred when he was even in jail. He did serve jail time. Some of these assaults were very bad. On one of the initial assaults, the victim received 10 stitches in her face because he had pummelled her so bad. When he was in jail, he sent the victim letters. In one of the letters that he sent her talked about how ugly and fat and stupid that she was and how nobody would ever befriend her or enter into a relationship with her except him. He was basically doing this out of sympathy, and it went on and on.

A number of these cases he did receive fines at arraignment. When he went in at arraignment time in front of the judge, when the judge had maybe between 100 and 300 arraignments in the morning, he received a fine when he pled guilty. Our office usually is not involved or in the court at that time.

This abuser number one went on and he was charged with aggravated assault on his mother. He fractured her hip above a prosthesis. He again received a lengthy jail term and just was released from jail recently on this and has just been arrested on new domestic assault charges on his former girlfriend, neither of which would have been the first two victims in his tirade.

Because of a bill in this State that Mary Cathcart presented to the Legislature a couple of years ago that Lieutenant Winslow mentioned, if you have two or more convictions of certain domestic crimes, the third one will be a felony. He was convicted on that also on his mother.

And his brother also has a pattern of domestic violence and also has been convicted of aggravated assault where he has more than two prior domestic assaults or domestic crimes on his victim.

I'd like to go to another case that I know.

Senator COHEN. Has he been prosecuted for a felony now?

Ms. CLIFFORD. Both of them have. Both of them have been sentenced to jail time and he—the first one that I mentioned, he is out on bail because of the two new assaults on the prior girlfriend. He's awaiting trial on those. But the brother is in jail at this point because he's serving a sentence for aggravated assault.

The second situation I'd like to address is abuser number two. I work up here in Penobscot County as Assistant District Attorney. I have also worked in Cumberland County, in Portland, for a couple of years before I moved up here.

And when I was down there, I had contact and met the victim of a domestic abuse, and she indicated to me that she had involvement up here as a victim. And when I came up here, the name was kind of distinctive and I found out some more information about it.

So when this abuser number two was prosecuted in Portland, the court certainly had no information whatsoever that this person had been convicted of domestic assault or abuse in any way in the State. There's no communication, no computer hookup between any of the prosecutorial districts in the State of Maine. And I only found out what information I did after the sentence had been imposed and his probation was being revoked because of domestic abuse. Up here in Bangor when he was prosecuted for assaulting his victim, he had broken her jaw and he received a fine at arraignment.

The judicial component here is only part of the process. And as Lieutenant Winslow addressed and I believe Dr. Brown stated that they become involved after the fact, and that's the same as our office. We cannot offer the victim much. We have no prior relationship or long-term relationship with the victim.

Penobscot County is lucky, in the mid 1980's, District Attorney Christopher Almy and Spruce Run worked together to get a VOC grant, and we have a victim advocate who devotes all her time to victims of domestic abuse. She's only a part-time employee.

We do not have a lot of resources to combat this abuse epidemic. Normally, as part of the conviction and sentence, there's probation with counseling involved. There needs to be a specific counseling component, batterers intervention groups or something along those lines. And we certainly do not have any resources in this area to do that. We are trying to work hard at it so we can get those resources available.

But as everyone has indicated who's testified here today, we need to work together. And I'd like to encourage the medical profession to be part of an educational process, explain to their patients their options and tell their patients that the law enforcement is there to help them and encourage them to report any sort of abuse to law enforcement. Thank you.

[The prepared statement of Ms. Clifford follows:]

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June 15, 1994

William S. Cohen
Special Committee on Aging
Federal Building, Room 204
202 Harlow Street
Bangor, Maine 04401

Dear Mr. Cohen:

Enclosed please find my written statement for the field hearing on family violence to be held in Bangor on June 20, 1994.

If you have any questions, please call.

Sincerely,

Alice E. Clifford
Assistant District Attorney

AEC/klh

encl.

Mr. Chairman and members of the Senate Special Committee on Aging, I want to join with the others here today in welcoming you to our State of Maine and also to thank you for conducting this hearing.

My name is Alice Clifford. I am an Assistant District Attorney for Penobscot and Piscataquis Counties in Maine. I also serve on the Maine Commission of Domestic Abuse. In 1991, I chaired the committee which wrote the "Domestic Abuse Prosecution Model Policy" for the District Attorneys and the Department of the Attorney General.

Family violence is an enormous problem in our society. The nature of family violence is such that it extends through every socio-economic strata and encompasses all races. It effects everyone in our society in one way or another. No one is safe from this problem.

The problem of family violence is commonly passed from one generation to the next. It is a behavior children learn from their parents, aunts, uncles and neighbors. When coupled with society's acceptance and tolerance of violence, especially against women, this behavior is reinforced in a meaningful way and, unfortunately, is one of the major reasons that the incidence of family violence is growing in today's world. This tolerant attitude is reflected in many ways, most notably is how intrafamily violence is portrayed in the media.

The prosecutor's office in this district and the police have a pro-prosecution policy. This differs from years ago when officers used to walk the abuser around the block or tell the abuser to leave and "cool down". Family violence used to be considered a "family problem" where no outside intervention was thought to be necessary. This simply is not the case. Maine's model prosecution policy for domestic abuse cases has either been adopted or amended by all prosecutorial districts throughout the State. All of the State's law enforcement agencies are also required to have written policies for domestic abuse cases.

These policies have had an immense impact on the overall handling of these cases. Many victims now relate how police officers have helped them to realize that what was happening to them was a crime and that they did not deserve that type of treatment. More abusers are now being held accountable for their behavior, not only to their victim but also to society as well. Unfortunately, this has not been a universal change as society's attitude towards this phenomena is slow to change.

The prosecutors, police and judiciary should take on a leadership role in continuing to respond to and prevent family violence. Prosecutors and law enforcement have undertaken a pro-prosecution stance to help combat this problem. Police are arresting abusers and the prosecutors are following through on the process, right up to trial, even in cases where there are reluctant victim-witnesses. However, more is needed. Sentences in these cases, this time, are not consistent. The judiciary needs more resources so as to be able to formulate effective sentences. Batterers intervention programs have been developed and have been a positive element of probation. The sad truth, however, is that in rural areas, such as a majority of our State, batterers intervention programs do not exist. More of these programs are needed.

Also, funds should be made available to allow for the formation of task forces in local communities. These task forces should have representatives from all areas of the community that work with cases of family violence and would work with the judiciary, prosecution and police to form a consistent policy. The task forces would include representatives from the local battered women's organization, social services, medical services, law enforcement, educational services, etc. This would ensure an attack on family violence that is all-encompassing.

Education also needs to be a integral part in addressing prevention of family violence. Educational programs which address family violence need to be implemented from pre-school on to counteract the seeming societal acceptance of this problem. Again, the task forces, local battered women's organizations, the judiciary, prosecutors and the police can all assist in this process.

The Federal Government can help combat family violence by expanding victim service grants and other Federal grants, such as funding for domestic violence projects. These projects are extremely important because they are often the root organization through which many other organizations rely for training, support, etc. Finally, by implementing more Federal legislation, such as the Violence Against Women Act, along with the resources in which to effectively fund the legislation, the Federal Government can help to turn the tide of family violence.

Alice P. Clifford

Senator COHEN. Thank you very much, Ms. Clifford.

Can I just ask one question of Ms. Stark? Is it your judgment, perhaps even Ms. Dumond's as well, that the domestic assaults are increasing, or is it simply that more victims are coming forward because now they see that there are some options available where before they had a sense of powerlessness? Before they had no options, nowhere to turn, no shelters, no counseling, no courts that would listen, no viable options available, so they would end up going back, not reporting, or canceling complaints? What's your judgment? Is it increasing or is it just more coming out?

Ms. STARK. I think we have to say that both things are true. Obviously there has only been a reasonable police response to domestic violence for something less than 10 years and so we're certainly in a place where there is increased reporting; just because they feel that the police will respond well is a piece of it.

As soon as batterers actually get sentenced, that will also help people to come forward. But I think the other piece to look at is that homicide rates continue to go up for victims of domestic violence, and as long as the homicide rates continue to be going up, we have to believe that all the rest of this, the continuum of violence experience is also increasing just by extrapolation.

So I don't think we're at a place where we can say that we're turning any corners.

Senator COHEN. I tell you I became—and, Ms. Stark, I think you testified at one of my hearings on stalking. Stalking is a very, very serious crime in this country. I don't know what will turn out in the Simpson case, but it appears that there may be an element of that as well.

But I became involved, and I am becoming aware of stalking as a major problem confronting many, many thousands, tens of thousands of women every day, millions actually.

When the daughter of a *Washington Post* reporter, George Lardner, was a student in the Boston area, she had dated a certain individual for a couple of times and tried to break it off, which he would not agree to.

I think he slammed her down on one occasion, either broke some bones or struck her head on the sidewalk and caused her quite a bit of damage and at one point she got a restraining order.

You reminded me of this, Ms. Clifford, when you talked about the fact that the boyfriend said that "this didn't mean a damn thing to me. This isn't going to stop me at all."

Of course, it didn't. And the judge who handed down the restraining order was not aware of the prior assault that had taken place. And within a couple of weeks thereafter he shot her and killed her outside of a restaurant just in the suburbs of Boston.

And as a result of that, my own staff became involved and looked at it, and I in fact found that members of my own staff had been victims of stalking. And then when we started to look at it, it became a tremendous problem that men who stalk either their wives, ex-wives, or girlfriends, believe that they are entitled to possess them forever and allow no one to intervene.

And, of course, we are seeing some of that in this recent so-called celebrated case.

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But no one has the answers, Peggy Dumond. No one has all the answers. As Lieutenant Winslow said, he'd be sitting in the Oval Office if he did.

But it seems to me that for openers, we have to increase the penalties on those who engage in this type of behavior, abusive behavior, not simply a slap on the wrist, not simply probation with some counseling.

If it's physical violence, it ought to be treated much more severely than it is today. And we ought to have more options for women, for the victims of the violence, than we currently have.

The more you look at it, you understand why victims of abuse keep going back, when you start realizing there aren't many options available for many of the victims.

And so I think, number one, education is obviously needed. Dr. Brown has talked about this and Dr. McAfee has talked about it. Education within the health care profession and certainly within the social services but also in our court system and our police departments. That's why the act, the Violence Against Women Act, is going to contain some funding and have Federal grants to train police and prosecutors and court personnel on the nature of family violence as well as the physical, psychological, and economic impact of family violence.

We are now finally starting to get real, so to speak, about what's been going on for a long, long time. We simply haven't been willing to admit that life really isn't "the way it ought to be" as we profess it to be here in the State of Maine.

We have a serious drug problem in this country, in this State as well. And we have a tolerance of violence against women, and we have had over the years. That's got to change.

So it means education and it means resources, options for those who are victims, and real strict penalties, real strict penalties for those who engage in this type of behavior.

I want to thank all of you for the work that you are doing and certainly for the testimony you have given. It will be entered as part of the record, and hopefully this will give me and the Committee even more ammunition, as we argue and debate about the funding mechanisms that we must come up with, to say why this is really important.

And you talk about the priorities of dealing with crime, that we not reduce this to the level that, well, it's more of a social problem to be dealt with at a local level, we want to make sure that we do this effectively. Thank you all very much and I will announce we are adjourned.

[Whereupon, at 12:10 p.m., the Committee adjourned, to reconvene at the call of the Chair.]

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83-927 - 95 (120)

ISBN 0-16-046776-4